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ABSTRACT

A study was conducted to determine whether the New York City Health and Hospitals Corporation (HHC) is fulfilling dual public health and primary care missions of its Child Health Clinics, which provide services to 78,000 New York City children every year. Among the services provided by Child Health Clinics are health examinations for school and day care enrollment, treatment for typical childhood illnesses, and education of the child and family regarding prevention and illness management. This study was undertaken in the context of significant shifts in the health care field. Interviews and site visits were conducted at 19 Child Health Clinics and 5 pediatric divisions of other clinics operated by the HHC. Study findings show that the overall administrative support for the clinics is, with some exceptions, strong, and that the clinics provide a range of primary care services on a day-to-day basis regardless of insurance status. Many clinics now serve adolescents. Most clinics provide some assistance in securing insurance coverage. Findings also show that clinics could be a source of health care for more children in foster care. Many clinics run out of supplies and medications, and many do not make home visits. In some cases, clinics may be under-utilized, and in other cases, there are significant equipment and structural problems. System oversight and planning need strengthening so that clinics can provide the public health and primary services New York's children need. Seven appendixes contain the field study questionnaire, a table of data about the clinics, a list of task force members, maps of the clinic and other primary services sites, and a table outlining numbers of clinic users from 1993 through 1998. (SLD)

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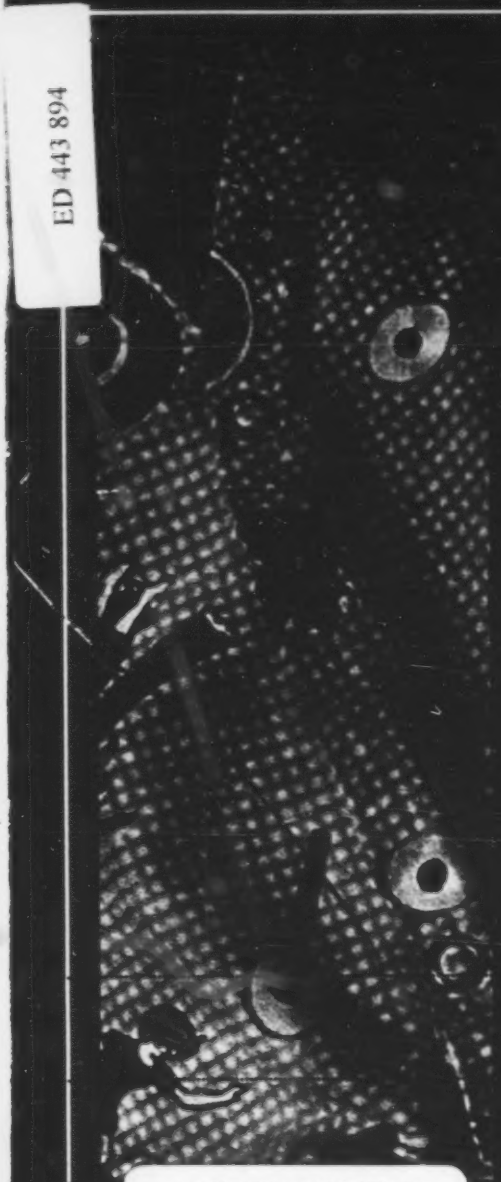

New York City's Child Health Clinics

Providing Quality Primary Care to Children in Low-Income and Immigrant Families

CCC

CITIZENS' COMMITTEE for CHILDREN OF NEW YORK

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CITIZENS' COMMITTEE for CHILDREN
OF NEW YORK INC

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Table of Contents

EXECUTIVE SUMMARY 2

CONTEXT FOR THE STUDY 6

METHODOLOGY 16

FINDINGS AND RECOMMENDATIONS 19

CONCLUSION 29

APPENDICES:

A. Field Study Questionnaire 31
B. Table of Selected Data 42
C. Task Force Members 45
D. Listing of Clinics 46
E. Map of the Child Health Clinics and Communicare Clinic Sites 47
F. Map of Other Publicly-Supported Primary Care Services for Children 48
G. Child Health Clinics Users – FY'93 Through FY'98 (HHC document) 50

Executive Summary

The Child Health Clinics provide primary health care services to 78,000 New York City children every year, care that in many cases is otherwise not available, because most of these children are uninsured. Citizens' Committee for Children of New York, Inc. (CCC) convened a Task Force of members of its Board of Directors and its Advocacy Council to conduct a study of Child Health Clinic staffing, services, policies and procedures throughout the City in January and February 1999. The purpose of the study was to examine whether the New York City Health and Hospitals Corporation (HHC) is fulfilling the clinics' dual public health and primary care missions while maintaining high quality and open access for low-income and immigrant children, regardless of their insurance status.

The study was undertaken in the context of a number of significant shifts in the health care field, including: the development and expansion of eligibility for publicly funded health insurance to children that has given low-income families more options in choosing health care providers; the growth in use of medical-home primary care models in providing health care to children; and, the impact of the advent of managed care in public sector programs, both on service delivery systems and on payment for services. The clinics have undergone significant administrative restructuring as well in their transfer from the City Department of Health (DOH) to HHC in 1994, and their integration into HHC's geographic networks in 1997 and 1998.

CCC's study surveyed nineteen Child Health Clinics and five pediatric divisions of Communicare[1] clinics operated by all seven of the HHC networks. Findings from the study showed that overall administrative support for the clinics from the HHC network offices is, with some exceptions, strong, and that the clinics provide a range of primary care services on a day-to-day basis. However, it was also clear that there are a number of areas in which the clinics would benefit from operational improvements, and in which HHC's ability to plan child health services must be strengthened to ensure that the clinics continue to provide high quality services to children in need of a primary care provider.

Selected findings from CCC's study, along with accompanying recommendations, are summarized below:

CLINICS PROVIDE A FULL RANGE OF PREVENTIVE AND PRIMARY CARE SERVICES AND MEET AMERICAN ACADEMY OF PEDIATRICS AND MEDICAID EARLY, PERIODIC, SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) STANDARDS. All the clinics provide routine check-ups and screenings and treatment of all routine infant and childhood illnesses, consistent with the standards of the American Academy of Pediatrics and the Medicaid EPSDT program.

MANY CLINICS NOW SERVE ADOLESCENTS. 75% (18) of the clinics CCC visited provide health care to adolescents. Only a few years ago, the great majority served children only up to age 13, but now most clinics are making the transition to providing adolescent care by continuing to serve enrolled children after they reach age 13. A proper transition is vital because adolescent health care needs differ from those of children and require different training, furniture, and some additional services.

- **RECOMMENDATION:** Ensure that clinics providing primary care services to adolescents provide the full range of services, including reproductive services; that staff is appropriately trained to serve adolescents; that necessary equipment is available; and that clinic hours are accessible to adolescent schedules.

[1] The Communicare clinics, which are also part of HHC, provide outpatient primary care to children and adults in six community sites across New York City.

MOST CLINICS PROVIDE SOME ASSISTANCE IN SECURING INSURANCE COVERAGE. Financial counselors meet with the families of uninsured children in 83% (18) of the clinics to assist families with applying for Medicaid and Child Health Plus. However, 6 of the 18 had a financial counselor in the clinic only once each week or only referred parents to a financial counselor at another HHC facility.

- **RECOMMENDATION:** Ensure that a financial counselor is available on-site at least part-time in every clinic to enroll eligible children in Medicaid and Child Health Plus. Ensure that every family of an uninsured child seen meets with a counselor at the clinic and is encouraged to enroll their child and that the counselor assists the family through the enrollment process. These financial counselors must be trained to assist families in filling out forms and completing the enrollment process, as well as to provide information and referrals for Child Health Plus, Medicaid, and Medicaid Managed Care.

CLINICS COULD BE A SOURCE OF HEALTH CARE FOR MORE CHILDREN IN FOSTER CARE. Clinics do not collect information from children and families regarding foster care status. CCC's study asked clinic staff how many children served at each clinic were in foster care, but clinic staff members could not respond to the question. Information from other sources indicates that many foster children have significant unmet health needs and that their access to regular primary care is often compromised. Given concerns regarding overall accessibility of health care to foster children and efforts by the New York City Administration for Children's Services (ACS) to ensure that foster children receive primary care, the clinics could be a significant resource for primary care services to them.

- **RECOMMENDATION:** Maximize utilization of clinic services by New York City children in foster care without primary care providers by creating a mechanism for ACS and voluntary foster care agencies to refer children to the clinics for primary care services. Ensure that every clinic becomes part of the ACS preferred provider list currently in development.

MANY CLINICS RUN OUT OF SUPPLIES AND MEDICATIONS. Though all clinics stated that they dispense medications on site, five clinics (21%) said they had run out of medications and/or supplies "often" in the past three months, and another 10 clinics (42%) said they had run out "sometimes" in the past three months. When asked what types of medications and supplies they had run out of, medications were most typically cited (13 or 87% of sample), but vaccines (4), laboratory supplies (3), medical supplies (5), office supplies (6), cleaning supplies (3), and educational materials (3) were also mentioned.

- **RECOMMENDATION:** Develop a reliable mechanism to ensure that all outpatient and ambulatory clinics that dispense medications and use laboratory, office, and other supplies are able to maintain sufficient supplies on site at all times. The HHC Office of Child Health should survey the clinics to identify problems in the distribution of medications and supplies, and monitor each network quarterly to ensure that medications and supplies are continuously available to patients and clinic staff so that clinic functions are not impaired and children are not at risk of going without needed medications.

MANY CLINICS DO NOT MAKE HOME VISITS. Only 63% (15) of the clinics said that they make home visits. Staff at the nine clinics that did not make home visits said that they had been told that it was no longer allowed, either after the transfer of the clinics from DOH in 1994, or after the integration of the clinic into the network. Only 4 (17%) clinics said staff would make a home visit as a last resort to follow up with a child who had missed appointments, which is of concern to CCC, since not every family can be contacted by telephone.

- **RECOMMENDATION:** Require staff in every clinic to make home visits when it is appropriate in the judgment of clinic professional staff, for example, to find a child who has missed appointments when his/her family is not reachable by telephone, or to evaluate a child's environment for health risks. These visits can be made by clinic staff or by public health nurses from a Certified Home Health Agency.

Develop guidelines for public health nursing that include making home visits and promulgate them with all the clinics. Develop and promulgate a protocol regarding appropriate referrals to DOH for home visits for window falls, lead abatement, and tuberculosis cases.

CLINICS MAY BE UNDERUTILIZED. Information collected by Task Force members during site visits provided indications of utilization declines at several clinics. In five (21%) of the 24 clinics visited, CCC Task Force members were unable to interview parents/caregivers because the clinics were empty – only staff were present. While it may be that the absence of patients was due to the time of day of the visit or some other issue of timing, it happened often enough to raise concern. In an additional 8 clinics (33%), staff expressed concerns to Task Force members about utilization declines or about the clinic's ability to conduct outreach. In fact, HHC data show a 23% decline between City Fiscal Years 1993 and 1998 in the number of patients served at the clinics (the number of users declined from 100,331 to 77,736)[2]. During the same period, four Child Health Clinics closed permanently, and three Child Health Clinics were converted to Communicare sites, which contributed significantly to the drop in the number of children served. This drop in utilization may have leveled off, since the number of patients served between FY 1997 and FY 1998 did not decline: in 1997, the Child Health Clinics served 78,439 children; in 1998, 77,736 children were served and during that year approximately ten sites were closed or temporarily consolidated for all or part of the year for renovations or repairs.

- **RECOMMENDATION:** Conduct a major outreach effort to promote the services of the Child Health and Communicare clinics with the goal of ensuring that all New York City children without a source of quality primary care be enrolled at a Child Health or Communicare clinic. Target specific populations with large proportions of children lacking regular primary care providers, such as children in foster care, adolescents, recent immigrants, children currently served in the Department of Health's School Examination Clinics[3], babies born at home, and children living in close proximity to clinics. In addition, ensure that all HHC hospitals refer all newborns in need of primary care services to a clinic in a convenient location. As part of this effort, analyze utilization data by clinic and network to determine clinic utilization patterns and why clinic utilization citywide has decreased.

PHYSICAL PLANTS VARIED GREATLY; SOME CLINICS HAD SIGNIFICANT EQUIPMENT AND STRUCTURAL PROBLEMS. When asked if the clinic had experienced physical plant problems in the past three months, staff at 3 clinics (13%) said they had them "often," and staff at 15 clinics (63%) said "sometimes." The physical plant problems consisted mostly of lack of heat (7 clinics), telephone problems (5 clinics), and leaks or plumbing problems (8 clinics).

Most clinic staff said it took a single day or less than a week to fix physical plant problems, but five clinics (5 of 18 with physical plant problems – 28%) said that problems had not been fixed. Examples of problems that had not been fixed included: water leaks (cited by four clinics); mice infestations; rotary telephone systems and problems with telephone lines; lack of storage; windows that would not open; windows that would not close; heat and air conditioning problems; and peeling paint and plaster. Additionally, 35% (8 of 23) of the clinics were not clearly identified on the outside of the building, and 29% (7 of 24) of the clinics had neither a working entrance buzzer nor a security guard.

2 See Appendix G for HHC utilization data.

3 The School Examination Clinics, which provide annual school examinations to 15,000 children a year, are slated for closure. The City Department of Health will have the task of ensuring that all children seen in the School Examination Clinics are referred to primary care providers.

- **RECOMMENDATION:** Ensure that all clinics in need of capital improvements and renovations are part of capital investment plans and that individual plans are executed and are monitored centrally by HHC, whether the owner of the facility is DOH, NYCHA, or a private landlord.

SYSTEM OVERSIGHT AND PLANNING NEEDS STRENGTHENING. While this study focused on policies and procedures at the clinics and not on the operations of the HHC administration, it was clear from some findings in this study that essential systemwide initiatives on behalf of the clinics need support from the HHC central administration. The Office for Child Health can also play a significant role with a number of vital functions, including: ensuring that clinics continue to collaborate with DOH to address public health and community health concerns; that each network provides a training curriculum to child health staff that is consistent and relevant to child health treatment and clinical issues; and that needed renovations are completed in a timely fashion, even if the actual work is the responsibility of DOH or NYCHA.

- **RECOMMENDATION:** Strengthen the Office for Child Health to allow it to plan for pediatric services citywide in the following ways:
  - Assessing unmet need for pediatric primary care services by neighborhood, in order to plan for potential additional services in and locations of clinics;
  - Assisting facilities with identifying strategies to promote Child Health Plus and Medicaid enrollment;
  - Replicating the medical home model used in the clinics in ambulatory care divisions in other HHC facilities;
  - Developing and publicizing prevention and education campaigns for HHC around specific child health needs such as lead poisoning, asthma, and child development;
  - Assisting networks with developing and disseminating education and screening materials for child specific neighborhood health fairs; and
  - Recruiting parents/caregivers of clinic patients for membership on HHC Community Advisory Boards to reflect the needs of clinic patients in the community advisory process.

Context for The Study

About the Child Health Clinics

The Child Health Clinics were established in the early 1900s as clean milk stations for poor children. Their mission later expanded to provide health education and referrals. Today, Child Health Clinics are safety net health care providers for low-income children in neighborhoods across New York City and provide a medical home as well as preventive care and public health services to infants and children up to age 18 (some serve children through age 12). Their services include well child visits/check-ups; health examinations for school and day care enrollment; immunizations; treatment for typical childhood illnesses; and education of the child and family regarding a range of prevention and illness management issues.[4]

The 39 Child Health Clinics are housed mostly in DOH District Health Centers and low-income housing projects and are open primarily during weekday hours. Some also have evening hours once or twice a week and/or Saturday hours. Clinic staff includes pediatricians, trained public health nurses, public health assistants, clerks, and laboratory associates, with the doctors, nurses, and public health assistants divided up into primary care teams. In addition to primary and preventive health care services, the clinics also operate special public health initiatives in asthma screening and treatment, child sexual abuse protection, HIV testing and referral, and thalassemia and sickle cell anemia screening, among others. In FY'98, 77,736 children received services at a Child Health Clinic; approximately 60% of them were immigrants; approximately two-thirds had no insurance coverage. The clinics provided 243,174 visits in total.[5]

Approximately one-third of children seen by the clinics are enrolled in Medicaid. Clinics are also educating families about the Child Health Plus insurance program. The great majority of children seen in the clinics are eligible for either Medicaid or Child Health Plus. However, the clinics treat children regardless of their insurance status and do not charge patients or their families fees for their services.

The clinics had an annual operating budget of $21 million in City Fiscal Year 1999, which ended June 30, 1999. Revenue for this budget was from the following sources: $5.4 million from City Tax Levy funds; $3.7 million from New York State Article VI public health funds; approximately $8 million from billing Medicaid; and the rest from HHC out of its own budget. The New York City Council supported the clinics with an additional $3 million in funds in the City's Fiscal Year 1999 budget to assist HHC in filling the clinics' budget deficit and will do the same in the Fiscal Year 2000 budget.

In 1993, Mayor David Dinkins proposed a transfer of oversight of the Child Health Clinics from the Department of Health to the Health and Hospitals Corporation. The Administration's rationale for moving the clinics to HHC was that it made sense to consolidate all publicly funded treatment services under one organization – HHC – and that it did not want DOH to continue to provide direct health services. As in most hospitals and hospital networks, the majority of care provided by HHC is inpatient acute care to its patients, but as managed care trends and government-imposed cost containment strategies have reduced payment rates for inpatient services and the length of most hospital stays, HHC has found itself with empty hospital beds and an ever greater need to provide outpatient treatment and primary care services. The transition from a bed-focused health care system to one that places greater emphasis on outpatient, primary, and preventive

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4 "The mission of The Child Health Clinics of New York City is to provide primary and preventive health care to infants and children who may not otherwise receive such services and to assure that the content and quality of care provided are consistent with accepted standards of the New York State Child/Teen Health Program (C/THP) and the American Academy of Pediatrics; to incorporate public health principles for a variety of conditions affecting the health of children; to closely collaborate with programs of the New York City Department of Health; and to serve as laboratories for innovation and 'best practices' research in public health and the delivery of primary care." Source: *The Child Health Clinics of New York City.* February 1997. New York: HHC.

5 See Appendix G for HHC data.

care makes the Child Health Clinics an asset for HHC. Clinic staff provides primary care and treatment services with an emphasis on prevention and education of the family. This is the model of care that managed care organizations support and that HHC will need to build on to stay competitive with other health care provider organizations.

However, despite the strategic value of the clinics to HHC and despite HHC's mission to serve the City's residents without regard to their ability to pay for care, there was concern among advocates and other groups and individuals in communities that the clinics might lose their public health focus and their ability to quickly implement responses to the emerging health care needs of the City's children. The transition of the clinics to HHC was delayed by these concerns but finally did take place in 1994 in the form of a contract between DOH and HHC which has technically expired but is still in effect while the two agencies negotiate a new one.

In the transition from agency to agency, the administrative structure of the clinics as a single network remained intact. Over the next few years, the clinics came under siege financially as Mayor Rudolph Giuliani made five attempts over four years to end the City's Tax Levy investment of $6 million a year in the clinics. Each time, the City Council restored the funds and the cuts were not enacted.

In June 1997, with the City Tax Levy funding safe for the time being, Luis Marcos, MD, President of HHC, announced plans to transfer oversight of the individual Child Health Clinics to the HHC network in each clinic's geographic area. The rationale for this administrative change was that the administrative structure of the clinics had been inherited from DOH and did not fit with HHC's own administrative structure. This "integration" was completed in January 1998. Although HHC maintains central oversight of some clinic functions, essentially their operation is the responsibility of HHC hospitals.

The challenge facing the clinics is to proceed simultaneously on two tracks. First, they must continue to fulfill their mission of providing a medical home with "primary and preventive health care to infants and children who may not otherwise receive such services." In addition, the clinics, with the assistance of the central HHC administration and DOH, must analyze where those children live and other salient characteristics, such as age and health status, in order to plan for potential service enhancements and additional locations of clinics.

The second track is to assist all insurance-eligible children with enrolling in Medicaid and Child Health Plus, both to increase the number of children covered by insurance and to improve their access to health care overall. This will also provide the clinics with more stable sources of revenue to cover the cost of the services they provide. City subsidies to clinic services have been threatened before and may well be threatened again. Uninsured but insurance-eligible children present a significant untapped source of revenue to enable the clinics to reduce reliance on City subsidies and cover the cost of care.

At the same time as the clinics work to enroll children in insurance programs, however, they must also ensure that the quality of care in the clinics remains high and that investments are made to maintain and, when needed, upgrade clinic facilities.

THE CHILD HEALTH CLINICS: A HISTORY

In the late 1890's, the City's Board of Health (BOH) raised concerns about poor milk quality and the need for pasteurization to prevent contamination after it found that the majority of milk sold in the city was handled, shipped, or stored incorrectly or carelessly. Diarrhea and dehydration brought on by contaminated milk accounted for a large percentage of infant deaths.[6]

In response to this need, Nathan Straus, a philanthropist and businessman, in 1894 began opening milk stations (and pasteurization plants that supplied them) where poor families could obtain clean milk at low or no cost. Several private individuals and associations followed his lead.[7] The milk stations became part of a greater trend toward use of preventive health measures in the developing field of public health.

The Child Health Clinics were originally established as clean milk stations, opened in the early 1900's to provide city children with free pasteurized milk, largely as a result of rising public concern over high infant mortality. While the exact infant mortality rate during this time period is difficult to determine, estimates range from 13.5% citywide to 70% in some neighborhoods. Several new state laws called for improvements in agencies caring for children as well as in factories employing them, but despite these efforts and the establishment of a special Infant Hospital on Ward's Island, infant mortality rate remained high.[8]

In 1907, the New York City Department of Health established the Division of Child Hygiene (DCH), with Dr. Josephine Baker as its first director.[9] Dr. Baker, like Mr. Straus, was committed to lowering the infant mortality rate. In fact, the DCH was the first public health unit to be charged exclusively with the promotion and protection of children's health. Its establishment represented a major shift in policy for the department, which had previously reacted to illness instead of preventing it, and a significant advance toward improving public health conditions and infant and child welfare.[10] Dr. Baker stated: "(P)ublic health work among and for children can be made preventive in its highest meaning, and the results are well worthy (sic) of all the time, money and energy expended in producing them."[11]

One of Dr. Baker's first initiatives was the blanketing of the Lower East Side, the home of thousands of poor, immigrant families, with 30 DCH nurses in the summer of 1909, using birth certificates to find all newborns and to instruct their mothers in infant care and feeding techniques.[12] At the end of the summer, 1200 babies' lives had been saved through this educational program.[13] The home visiting activities eventually became integrated into the work of the milk stations.

By 1909, Straus was operating 17 infant milk stations. However, in response to public debate and sharp criticism of his milk pasteurization plants in the New York Herald, a daily newspaper, he gradually transferred his depots to the City's control, negotiating an agreement that the Department of

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6 Public Health Monographs, Volume 1, Numbers 1-10.

7 John Duffy. 1974. *A History of Public Health in New York City.* New York: Russell Sage Foundation.

8 Bureau of Child Health August 1989. *A Chronological History of Child Health in New York City.* New York: New York City Department of Health.

9 Ibid.

10 Ibid.

11 S. Josephine Baker, MD. April 1912. *"The Value of the Municipal Control of Child Hygiene."* Speech before the Section on Public Health of the Medical Society of New York State. Printed in the *American Journal of Obstetrics and Diseases of Women and Children.* Vol. LVI, No. 6, 1912.

12 Margaret Thorne Grossi, MD. 1998. *"Comments on the Occasion of the Child Health Clinics receiving the Primary Care Achievement Award."* Unpublished notes.

13 Leona Baumgartner. June 1969. *"One Hundred Years of Health: New York City, 1966-1966" in Bulletin of the New York Academy of Medicine,* Series II, Vol. 45, No. 6. New York: The New York Academy of Medicine.

Health would not only take over the operation of the stations but open new ones as well.[14] Dr. Baker sought funding for the development of child health centers and attempted to raise public awareness of infant and child health, but it was the uproar caused by the Herald's attacks on Straus which inspired action by City government.[15]

In April 1911, the City opened the first of 15 planned milk stations proposed by the Health Department for that year. Their total budget was $40,000. The next year, they numbered 54, and most private milk stations were either closed or in the process of closing.[16] By 1912, the infant mortality rate had fallen by 42% to 105 deaths per thousand live births, from 181 in 1902.[17]

The New York Milk Committee, made up of private citizens who provided oversight for the stations, saw a trend toward providing public and preventive child health services in the milk stations. In its 1914 Annual Report, the Committee stated: "The station(s) (are) slowly developing into a community information bureau. Whole families are coming for assistance and advice."[18] The DCH was now operating 56 milk stations and overseeing 7 others run by voluntary agencies.

The City Department of Health changed the name of the program to "Baby Health Stations" in July 1916. In the five years since it had taken over operations, the stations' function had expanded from that of milk depots to health and education centers offering public health information to families. [19]

The number of Baby Health Stations throughout the city reached 68 by 1920. Each station employed a nurse and a nurse's assistant, and one medical inspector (a medical doctor) had oversight of every three stations. During warm months, when infant health declined, an additional nurse was assigned to each station. During this time period, the Department of Health also took over Straus' milk pasteurization plant. By 1925, there were 70 Baby Health Stations in operation.[20]

In 1928, pediatricians were first employed at the Baby Health Stations to provide direct health care services. This expansion in staff led families to bring older children in for medical care, and eventually the clinics were renamed "Child Health Stations." During the '20's, '30's, and '40's, the stations made great progress in providing immunizations to children and combating communicable diseases, including diphtheria, whooping cough, and tetanus. And in the 1930s, when the City launched major construction initiatives for publicly funded housing projects in various parts of the five boroughs, Child Health Stations were built in many of them. While the historical record is incomplete for the 1940s through the 1960s, it is clear that by 1960, one third of all infants born in New York City (55,000 newborns), as well as 22% of all children in preschool, were enrolled for health care at a Health Station.[21] There were 99 Child Health Stations open in 1966.[22]

In the early 1970's, 21 of the 95 Child Health Stations were converted into Pediatric Treatment Centers, which continued to be operated by the Department of Health. These Centers, conceived partly in response to a drop in enrollment in the Child Health Stations, were designed to treat minor illness, a service that the Stations did not provide, in addition to providing well-child care and checkups. By providing primary care to children, Stations could reduce the use of hospital emer-

14 Duffy, 1974.

15 Ibid.

16 Ibid.

17 Bureau of Child Health. August 1989. *A Chronological History of Child Health in New York City.* New York: New York City Department of Health.

18 New York Milk Committee Annual Report. 1914. New York: Author.

19 Duffy, 1974.

20 Ibid.

21 Ibid.

22 Bureau of Child Health. August 1989. *A Chronological History of Child Health in New York City.* New York: New York City Department of Health.

gency rooms.[23] By 1990, all the Child Health Clinics were providing treatment services.

DOH was hit hard by the City's fiscal crisis in the mid-1970s, which led to the closing of twenty-two of the 78 operating Stations and Pediatric Treatment Centers.[24] Not much later, in 1983 when 98,000 children ages 0-6 were enrolled in the Child Health Stations and Pediatric Treatment Centers, DOH made plans to close 10 more Stations due to "underutilization" and the availability of other resources in those communities. However, when identifying "other resources," the Department did not consider financial or geographical barriers that would prevent families from accessing these services. As well, there was concern on the part of advocacy groups and public officials that cutbacks in staff and clinic hours had caused much of what DOH interpreted as "underutilization." In the face of substantial opposition, the Health Commissioner abandoned the plan to close the Stations.[25] It was also during the fiscal crisis that the clinics began to bill Medicaid for services provided to Medicaid-enrolled children. However, the great majority of children served in the clinics were not eligible for Medicaid and were therefore uninsured.

In 1987, the Child Health Stations established an immunization database for all clinic users. This allowed the Stations to maintain a record of a child's immunizations to ensure that they were complete and prevent unnecessary duplication. The database was the forerunner of a citywide immunization registry for all children that began operations in the mid-1990s, with virtually all of the city's health care providers reporting information into it.

By the end of the 1980s, all of the Stations were providing treatment of common childhood illness and dispensing medications, and the name of the program was changed in 1990 to Child Health Clinics to reflect this range of service provision. The clinics continued to provide information, education, and regular checkups to children.

Challenges Facing the Clinics

An examination of the Child Health Clinics requires a look at the larger issues affecting the provision of pediatric primary care services. They include: concerns about access to primary care and prevention services for low-income children; the development and expansion of eligibility for publicly funded child health insurance, which creates more options for low-income families seeking health care for their children; and the impact of the advent of managed care on public sector programs, both on service delivery systems and on payment for services.

ACCESS TO PRIMARY CARE SERVICES

Primary care is defined as an ongoing relationship with a provider or team of providers who act as the regular point of entry for the child and family and who provide and/or coordinate a full range of services including preventive, diagnostic, treatment, and follow-up care. Available types of primary care to children and adolescents vary widely depending on the communities in which families live, as well as on family income and insurance status. In New York City, families with private employer-based health insurance coverage tend to rely on doctors in private offices for services. For children who are uninsured, underinsured, or on Medicaid or Child Health Plus, public and voluntary hospitals, community-based health centers, and storefront doctor's offices provide most medical services.[26]

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23 Lloyd F. Novick, MD, MPH, Anthony Mustalish, MD, MPH, and Gary Eidsvold, MD, MPH. September 1975. *"Converting Child Health Stations to Pediatric Treatment Centers."* Medical Care, Vol. XIII, No. 9.

24 Sylvia Pirani. May 1986. *Planning and delivery of health services for children: How New York City rates as a system.* New York: Columbia University.

25 Ibid.

26 Child Health Plus, until January 1997, covered children up to age 15. The program now enrolls children up to age 18. Medicaid enrolls children up to age 18 as well, though children who stay in foster care after they turn 18 continue to be eligible for Medicaid until they are 21.

A 1997 national study found that children in low-income families faced significant barriers to accessing regular medical care: 25% of children in families with incomes under $20,000 a year had not obtained medical care of any type in the past year, 18% had no regular doctor, and 21% of children's families had difficulty in paying their medical bills.[27] A New York City study found that 40% of the City's uninsured children did not have a regular source of medical care.[28] The high rate of hospitalization due to asthma among children in New York City is an example of a problem that could be prevented through regular primary care.[29]

One measure of access to regular primary care among low-income children is the federal Medicaid Early, Preventive, Screening, Diagnosis and Treatment (EPSDT) standard, which requires that every child enrolled in Medicaid receive regular screens (also called checkups), and that any illness or health, mental health, or developmental need diagnosed during a checkup be treated until corrected or ameliorated. Even according to this standard, which measures services to children insured by Medicaid, most children do not receive appropriate health care. Of the 22.9 million children enrolled in Medicaid and eligible for EPSDT in 1996, only 37 percent actually received a medical screen through EPSDT.[30]

While many low-income and immigrant children do not receive regular primary care, the children served by the Child Health Clinics are low-income and most of them are immigrants. A limited number of School-Based Health Clinics and Pediatric Resource Centers also function as a safety net, providing primary care services specifically to children and adolescents. Located in just 140 of the City's 1136 public schools, the School-Based Health Clinics provide primary care, education, and in some cases mental health services to children and adolescents during school hours. Each clinic is sponsored by a hospital or nonprofit organization that employs and coordinates staff and provides back-up services.

Eight Pediatric Resource Centers, each operated by a public hospital or a voluntary institution, provide comprehensive primary care to low-income children and adolescents from households with incomes at or below 185% of poverty, who are at risk for poor health outcomes, and who live in high-need service areas. The Centers provide all preventive services (health maintenance, screening tests, and immunizations) free of charge to all patients regardless of the age of the child. In 1997, 28,000 children were registered to receive care at a Pediatric Resource Center.[31] Even with these facilities serving children, however, many neighborhoods throughout New York City still have significant shortages of primary care capacity.[32] Neighborhoods with high proportions of low-income residents have more acute shortages of primary care providers. Many Child Health Clinics are located in such neighborhoods (see Appendix F).

UNIVERSAL CHILD HEALTH INSURANCE

One of the reasons primary care options are limited for low-income children is that large numbers of them are uninsured. The American

27 Kaiser/Commonwealth 1997 National Survey of Health Insurance. Quoted in: Cathy Schoen. May 1998. *Financing Children's Health Care in the Next Century.* New York: The Commonwealth Fund. Presentation.

28 Cathy Schoen and Catherine DesRoches. May 1998. *New York City's Children: Uninsured and at Risk.* New York: The Commonwealth Fund.

29 82.9 children per 10,000 were hospitalized for asthma in New York City in 1996, four times the rate of hospitalization in the rest of New York State. Source: Citizens' Committee for Children of New York, Inc. February 1999. *Keeping Track of New York City's Children.* New York: CCC.

30 Kristi Olson, Jane Perkins and Tonya Pate. August 1998. *Children's Health under Medicaid: A National Review of Early Periodic Screening, Diagnosis and Treatment.* Los Angeles: National Health Law Program.

31 Citizens' Committee for Children of New York, Inc. August 1998. Child Health: A Community Leadership Course Policy Paper. New York: CCC.

32 John Billings, Jessica Greene and Tod Mijanovich. March 1998. *Analysis of Primary Care Practitioner Capacity for Medicaid Managed Care in New York City.* New York: NYU Health Research Program.

Academy of Pediatrics projects that there are currently 765,000 uninsured children in New York State.[33] 340,000 of them live in New York City.[34] Over time, the number of uninsured children has grown significantly because of a decline in the number of employers offering health insurance coverage to working families and increases in the cost to employees of that insurance coverage.[35] While health insurance coverage does not guarantee access to health care, uninsured children face disadvantages in accessing well-child and preventive care, and are more likely than insured children to become ill and to rely on emergency care.

Title XIX of the Social Security Act established Medicaid, a health insurance entitlement program that covers both children and adults, in 1965. Beginning in 1996, Medicaid enrollment in New York City began falling steadily. The number of children enrolled in New York City went from a high of 1,519,744 in March 1995 down to 1,332,917 in October 1998, the most recent figure available. This constituted a drop of 176,500 children, or 12%.[36] While the Federal Health Care Financing Administration (HCFA) is investigating reasons for drops in the Medicaid rolls in New York State, it is generally assumed that the decreases are tied directly to a substantial decrease in the welfare rolls since 1996, either because those leaving welfare have jobs and no longer need Medicaid, or because those leaving welfare have not been apprised of their continued eligibility for Medicaid coverage and have fallen into the ranks of the uninsured.[37]

Lack of health insurance coverage for children in working families is also a significant problem and has been well-documented, both nationally and in New York. A 1997 study showed that 72% of uninsured children in the City live in working families.[38] New York State was one of the first states to recognize significant growth in the number of uninsured children as an issue deserving public policy attention. In response to the great need for insurance coverage, Governor Mario Cuomo and the New York State Legislature created Child Health Plus in 1991 and Governor George Pataki and the Legislature subsequently increased funding to the program in the New York State Health Care Reform Act of 1996. Child Health Plus is a government-subsidized insurance program, contracted through managed care plans, for children up to age 18 in low-income families who are not eligible for Medicaid coverage, and is available through managed care plans contracted with the State Department of Health. Families are either fully subsidized or make monthly contributions to the premium of $9 or $15, depending on income. Program enrollment statewide grew from 25,000 children in 1992 to 312,981 at the end of April 1999. 164,521 children were enrolled in New York City in April 1999.[39]

In response to nationwide concern over growing numbers of uninsured children, the Federal government created the State Child Health Insurance Program (SCHIP) in the Balanced Budget Act of August 1997. This program now allocates $256 million to New York State every year for health insurance coverage for children. In

33 American Academy of Pediatrics. March 1999. *"Medicaid and State Program Eligibility of Uninsured Children under Age 19, 1999 Projections."* www.aap.org.

34 Ibid.

35 Families USA Foundation. March 1997. *One Out of Three: Kids Without Health Insurance, 1995-1996.* Washington, D.C.: Families USA.

36 New York Forum for Child Health. May 1999. *Monitoring Children's Health Insurance Enrollment in New York State.* New York: The New York Academy of Medicine.

37 National Health Law Program. Spring 1999. "Legal Strategies Restore Medicaid Benefits," in *Health Advocate.* Los Angeles: NheLP.

38 Ibid. Schoen and DesRoches. *New York City's Children: Uninsured and at Risk.*

39 New York State Department of Health. Bureau of Health Economics. 1998. *1998 State Legislation: Children's Health Insurance.* (presentation). New York State Department of Health. June 1999. *Child Health Plus Program Enrollment by County as of April 1999.* www.health.state.ny.us/nysdoh.

June 1998, Governor George Pataki and the New York State Legislature allocated SCHIP funds to slightly increase Medicaid income eligibility and to substantially augment the Child Health Plus program by increasing income eligibility levels, increasing the benefit package, and eliminating co-payments for services.

Since Medicaid enrollment has decreased as Child Health Plus enrollment has increased, it is difficult to predict how many children will be insured through each program when Child Health Plus becomes fully enrolled and Medicaid enrollment stabilizes and to determine if the sum total of uninsured children is increasing or decreasing in New York. A number of initiatives are being implemented by government agencies at all levels to try and enroll children in insurance programs, with the goal of ensuring that all children have coverage.

In the City, many children without health insurance are immigrants. While immigrant children are eligible for Child Health Plus, many families are reluctant to enroll them for fear of being deemed a "public charge" by the Immigration and Naturalization Service, a situation that may negatively affect the family's immigration status. In May 1999, the Federal government issued regulations that clarified that the immigration status of individuals will not be affected by use of public health services or by enrollment in Medicaid or any other publicly funded insurance program.[40] However, immigration advocates are still reluctant to encourage families to enroll their children in the program because Federal law states that immigrants who arrived in the United States after the enactment of the Personal Responsibility Act in 1996 are not eligible for any federally-funded health services other than emergency care. New York State does enroll immigrant children in Child Health Plus, and according to the May 1999 statement of Federal policy, this enrollment should not have any negative impact on a family's immigration status. Nonetheless, it remains a concern for many families.

MANAGED CARE

Managed care has changed the entire landscape of health care delivery and services, significantly affecting safety net providers. As more and more children on Medicaid have enrolled in managed care plans, providers have had to affiliate themselves with the plans to receive payment for providing services to managed care enrollees, particularly since Child Health Plus is only offered through managed care plans. In 1997, New York State applied for and received a Medicaid Section 1115 Waiver from the Federal government to allow the mandatory enrollment of most Medicaid enrollees in managed care plans. Mandatory Medicaid managed care will be phased in throughout the City starting in the fall of 1999. Although some populations are exempt, most children on Medicaid served by the clinics will have to enroll.

In addition, managed care plans must approve the provision of services to their enrollees and must retrospectively review utilization of services ("utilization review"), meaning that the plans make decisions about the types of care that are warranted instead of simply paying health care providers' claims. Because managed care plans impose a variety of physical plant requirements in facilities that affiliate with them, safety net providers may need to make capital investments in structures to ensure that they meet plan standards. The Child Health Clinics fulfill the requirements of managed care companies and are contracted to provide services with a number of them.

Even prior to the development of Medicaid and Child Health Plus managed care, however, the move to managed care affected publicly funded health programs through the private insurance market. Historically, many health care providers were uninterested in serving Medicaid enrollees because of their relatively greater need for services and bureaucratic barriers to receiving payment. Payment rates were typically lower than those of private insurance companies. This discrepancy ensured that Medicaid enrollees would continue to go to the Child Health Clinics and other safety net and public health

[40] Families USA Foundation. May 1999. *Immigrants and the Medicaid and CHIP Programs: Public Charge Guidance Released.* Washington, D.C.: Families USA.

service providers for care. At the same time, managed care plan enrollment in the private insurance market has brought down payment rates, making provision of services to Medicaid enrollees more attractive. In some cases, voluntary hospitals and other health care providers have opened their own community-based primary care sites, creating more competition to serve children in families traditionally treated by the Child Health Clinics and other safety net providers. Voluntary and for-profit hospitals and outpatient clinics now aggressively pursue Medicaid-enrolled children in particular, as most of them are healthy and cost relatively little to treat in comparison with the cost of treating adults.

THE MEDICAL HOME PRIMARY CARE MODEL

Children require regular visits to the doctor as they grow to ensure proper development and that all their medical, mental health, and developmental issues are addressed. The American Academy of Pediatrics (AAP) has developed and defined the term "medical home" to describe primary care services that meet the needs of developing children and adolescents. This model is used by the Child Health Clinics and, increasingly, by other health care providers serving children:[41]

The American Academy of Pediatrics believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. These characteristics define the "medical home" and describe the care that has traditionally been provided by pediatricians in an office setting. In contrast, care provided through emergency departments, walk-in clinics, and other urgent-care facilities is often less effective and more costly.

We should strive to attain a "medical home" for all of our children. Although geographic barriers, personnel constraints, practice patterns, and economic and social forces make the ideal "medical home" unobtainable for many children, we believe that comprehensive health care of infants, children, and adolescents, wherever delivered, should encompass the following services:

1. Provision of preventive care including, but not restricted to, immunizations, growth and development assessments, appropriate screening, health care supervision, and patient and parental counseling about health and psychosocial issues.
2. Assurance of ambulatory and inpatient care for acute illnesses, 24 hours a day, 7 days a week; during the working day, after hours, on weekends, 52 weeks of the year.
3. Provision of care over an extended period of time to enhance continuity.
4. Identification of the need for subspecialty consultation and referrals and knowing from whom and where these can be obtained. Provision of medical information about the patient to the consultant. Evaluation of the consultant's recommendations, implementation of recommendations that are indicated and appropriate, and interpretation of these to the family.
5. Interaction with school and community agencies to be certain that special health needs of the individual child are addressed.
6. Maintenance of a central record and data base containing all pertinent medical information about the child, including information about hospitalizations. This record should be accessible, but confidentiality must be assured.

While the Child Health Clinics have evolved this model of care provision over several decades, use of the medical home model for delivering primary care services to children has in recent years been more widely adopted by health care facilities, particularly with the spread of managed care, which emphasizes prevention and primary care provision.

[41] American Academy of Pediatrics. November 1992. *"The Medical Home." in Pediatrics* Volume 90, Number 5. Chicago: AAP.

THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

New York City's Health and Hospitals Corporation (HHC) has overseen the Child Health Clinics since 1994, when they were transferred from DOH. HHC was established in 1970 as a public benefit corporation with the mission of providing health care to those in need. It is the largest municipal health care system in the country, offering inpatient and ambulatory care in 11 acute care hospitals and 17 community-based satellite clinics. Many of its clinical services are provided through affiliation agreements with voluntary teaching hospitals, medical schools, and medical professional corporations.

HHC policy states that no one will be denied care due to inability to pay. As a result, HHC is the major provider of ambulatory care for uninsured children. Patients without Medicaid or other insurance are asked to pay on a sliding scale (with the exception of Child Health Clinics and Communicare clinics, which have no fees).

THE CONTRACT BETWEEN DOH AND HHC

The Child Health Clinics were transferred from DOH to HHC under a 1994 contract that also covered the transfer of "correctional health, dental health and communicare (sic) programs."[42] The term of the agreement was from November 13, 1994 to March 30, 1996, with the option of renewal for two additional two-year terms, one of which was put into effect. This transfer agreement expired in April 1998, but since the two agencies have continued to negotiate a new version, it is still considered to be in effect.

In the contract, HHC agreed to "administer, manage, maintain and operate a program to provide and ensure access to primary and preventive health care services to children at the Child Health sites." The scope of services for the sites included: Primary Care; Episodic Care; Special Care (including asthma management and immunizations); Public Health (including "responding to SIDS and window fall cases with home visits as part of public health nursing component"[43]); and Protocols for registration, eligibility, and staffing. It specified that in the event of catastrophic circumstances, which include capital construction, HHC and DOH could discuss "in good faith the possibility of modification of the scope of services."[44] The contract noted that all services described would be maintained by HHC unless HHC had received "written prior approval for any proposed change as to the scope of services."[45]

DOH's role was to exercise oversight, and in that vein, the agency was given the following powers: to review financial reports and audit revenue and expenditure reports; to inspect any site where services are offered with two days' notice; to make one unannounced visit to each site; and to evaluate delivery of services in writing. If DOH found deficiencies in services supported by Article VI public health funds, HHC was required to make a plan in writing for remedying those deficiencies. DOH required notification and authorization for some budget modifications, but not all.

In the area of capital projects, the contract noted that DOH would assist HHC in finding capital funds needed for full compliance with "applicable Codes and laws." It also stated that HHC would not be held responsible for any disallowances, fines, or liabilities resulting from a lack of compliance.[46]

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[42] DOH/HHC Transfer Agreement, Article I.

[43] Ibid., Annex A-1(Bureau of Child Health Scope of Services), Section D. SIDS is Sudden Infant Death Syndrome.

[44] Ibid., Article V.

[45] Ibid. Article V, Section 1.

[46] Ibid., Article IX, Section 7.

CC's study surveyed staffing and services available and their policies and procedures in 19 of the 30 operating Child Health Clinics and 5 of the 6 operating Communicare clinics operated by all seven of the HHC networks. The study did not audit medical records, nor did it assess standards of care at the clinics. Nine Child Health Clinics were closed due to renovations or structural problems at the time of the study.[47] Pediatric departments of Communicare clinics were included in the study because they provide primary care services to a population of children similar to that served by the Child Health Clinics. HHC has opened six Communicare clinics since 1996. Data collected from Communicare sites did not differ substantially from data collected from the Child Health Clinics.

CCC developed a site visit questionnaire (Appendix A) administered by two trained CCC Task Force members at each clinic, where they interviewed the Nurse in Charge, a member of the clinical staff who is also the clinic's administrator. The Task Force members themselves were child advocates educated regarding the basic functions and mission of the clinics. The site visit questionnaire focused on the primary care and public health services provided in the clinic, policies on payment for services, the status of the clinic's physical plant, and questions for parents of children receiving care at the clinic.

Twenty-four clinic site visits were made in January and February 1999. Each interview took approximately one hour, including both the clinic staff interview and short interviews with two parents. In addition, Task Force members met with administrators from four of seven HHC networks using a shortened version of the site visit questionnaire form. These network interviews took place with representatives from the Renaissance (North Manhattan), Generations Plus (South Bronx and East Harlem), Queens, and South Brooklyn/Staten Island networks.

Specific clinics visited were chosen to ensure a representative sample. The criteria for choosing them included: clinics from every HHC network; small, medium and large-size clinics in the number of staff employed and the number of visits provided; clinics in DOH, New York City Housing Authority, and privately owned buildings; clinics that had been renovated and those that had not; and clinics from all five boroughs and a range of neighborhoods in each borough. The clinics visited as part of the study are listed with the HHC network to which they report (a full listing of the clinics is in Appendix D):

[47] The following clinics were closed for renovations or because of structural problems during the period of the study: Baruch Houses (South Manhattan); Brevoort Houses (South Brooklyn/Staten Island); Forest Houses (Generations Plus - South Bronx and East Harlem); Howard Houses (South Brooklyn/Staten Island); Jonathan Williams (North Brooklyn); Lafayette Houses (North Brooklyn); Stapleton (South Brooklyn/Staten Island); Sumner Avenue Houses (North Brooklyn); and Woodside Houses (Queens).

CHILD HEALTH CLINICS VISITED

BRONX

Generations Plus Network

Daniel Webster Houses
401 East 168th Street

John Mitchel Houses
185 Willis Avenue

Melrose Houses
348 East 156th Street

North Bronx Network

Glebe Avenue
2527 Glebe Avenue

Tremont Avenue
1932 Arthur Avenue

BROOKLYN

South Brooklyn/Staten Island Network

Brownsville
259 Bristol Street

Crown Heights
1218 Prospect Place

Eleanor Roosevelt Houses
388 Pulaski Street

Fifth Avenue
665 Fifth Avenue

North Brooklyn Network

Bushwick Communicare
335 Central Avenue

Fort Greene
295 Flatbush Avenue Extension

Williamsburg
151 Maujer Street

Wyckoff Gardens Houses
266 Wyckoff Street

Coney Island Hospital Network

Homecrest
1601 Avenue S

Sheepshead Bay Houses
3525 Nostrand Avenue

MANHATTAN

South Manhattan Network

Alfred Smith Houses Communicare
60 Madison Street

Generations Plus Network

East Harlem
115 East 115th Street

Renaissance Network

Dyckman Houses Communicare
175 Nagle Avenue

Manhattanville
21 Old Broadway

QUEENS

Queens Network

Corona
101-04 Corona Avenue

Junction Boulevard
34-33 Junction Boulevard

Jamaica-Parsons
90-37 Parsons Boulevard

STATEN ISLAND

South Brooklyn/Staten Island Network

St. George
51 Stuyvesant Place

Hylan Avenue Communicare
2971 Hylan Boulevard

Methodological Limitations

Although the study intended to interview clinic staff only and despite an agreement between CCC and the HHC central administration that network staff would not participate, network administrative staff were present at 6 of the 24 interviews. Where administrative staff was not present, staff interviewed felt more comfortable speaking with CCC interviewers. In cases where network administrators were present, Task Force members felt that their presence affected responses of clinic staff to the questionnaire and therefore had an impact on data collected during the interview.

As part of the study, Task Force members administered survey questions to 36 parents/caregivers during site visits to the clinics. However, in 5 clinics, parents/caregivers were not in the clinic at the time of the site visit.

The questionnaire was written in easy-to-understand language with few medical terms so that the Task Force members administering it would not be using unfamiliar language in asking questions. As was agreed with HHC ahead of time, the questionnaire did not ask for numerical data so that clinic personnel would not have to review records or calculate figures to prepare for or during the interview.

CCC did not ask staff in individual clinics for any data that is collected by HHC centrally in its Pediatric Performance Indicators. Instead, CCC asked the HHC Central administration for specific data, including: number of clinic users; number of users enrolled in Medicaid and Child Health Plus Managed Care Plans; and percent of C/THP (Child/Teen Health Plan) or EPSDT exams completed.

According to data from CCC's study, overall administrative support for the clinics from the HHC networks is generally strong, and the clinics provide a full range of primary care services to children on a day-to-day basis. However, there are several areas that require operational improvements, and where oversight and management must be strengthened to ensure that the clinics continue to provide high quality services to children in need of a primary care provider. These areas include: clinic services and public health programs; clinic enrollment and utilization; physical plant; and insurance coverage and patient fees.

Clinic Services and Public Health Programs

CLINICS PROVIDE A FULL RANGE OF PREVENTIVE AND PRIMARY CARE SERVICES AND MEET AMERICAN ACADEMY OF PEDIATRICS AND MEDICAID EARLY, PERIODIC, SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) STANDARDS. All the clinics provide routine check-ups and screenings and treatment of all routine infant and childhood illnesses, consistent with the standards of the American Academy of Pediatrics and the EPSDT program. EPSDT sets required standards for providing regular primary and preventive care to children enrolled in Medicaid and sets a schedule for regular check-ups according to the child's age. Medicaid regulations state that any illness or condition diagnosed during an EPSDT examination must be treated until ameliorated or corrected. While many children enrolled in Medicaid do not receive all their regular check-ups, practice at the clinics has been and continues to be to see all enrolled children according to the EPSDT schedule of examinations and to treat them according to EPSDT standards, regardless of whether or not they have Medicaid.

As part of their services, all clinics screen enrolled children for vision and hearing deficits. Children in need of a full evaluation are referred to an HHC hospital and do not typically have a long wait for that evaluation. Once referred to an HHC hospital for a full evaluation, 21 of 24 (88%) clinics said that children referred for a full hearing evaluation wait less than six weeks for a hearing evaluation, and slightly fewer clinics (19 of 24 – 79%) said that children have to wait less than six weeks for a full vision evaluation.

Almost all of the clinics said that they provide education to children and families in each of the following areas: lead exposure; asthma management; nutrition; tuberculosis; child development; injury prevention; HIV/AIDS; sickle cell anemia; television watching; and gun safety.

When asked to characterize the operations of their clinic in the past six months, 67% of respondents (clinic staff) said "good," and 33% said "excellent." All but one parent/caregiver interviewed during the site visits felt their children were receiving excellent or good care, would return in the future, and would recommend the clinic to a friend.

MANY CLINICS NOW SERVE ADOLESCENTS. Seventy-five percent (18) of the clinics CCC visited provide health care to adolescents. Only a few years ago, the great majority served children only up to age 13, but now most clinics are making the transition to providing adolescent care by continuing to serve enrolled children after they reach age 13. While the interviews did not assess the clinics' ability to provide adolescent primary care (including reproductive health care services), it was clear that some clinics and networks had made this change carefully, ensuring that the clinic staff were fully trained and prepared to deal with the needs of adolescents, and that some clinics were less well prepared. A proper transition is vital because adolescent health care needs differ from those of children and require different training, furniture, and some additional services.

- **RECOMMENDATION:** Ensure that clinics providing primary care services to adolescents provide the full range of services, including reproductive services; that staff is appropriately trained to serve adolescents; that necessary equipment is available; and that clinic hours are accessible to adolescent schedules.

MANY CLINICS WORK WITH DOH TO ADDRESS LOCAL HEALTH CONCERNS. Collaborations with DOH to address a public health or community health concern occurred in 11 clinics (46%) during the six months prior to the study, though CCC did not define the term "collaboration." Using protocols put into place by HHC, the clinics are able to intervene and provide services to respond to immediate public health concerns, for example: tuberculosis; lead poisoning due to environmental contamination in the community; and communicable disease outbreaks.

- **RECOMMENDATION:** Ensure that the clinics continue to be able to respond to public health concerns identified by DOH, and use protocols in place to manage specific public health concerns that arise in a local community, including infectious disease outbreaks and environmental hazards.

MANY CLINICS RUN OUT OF SUPPLIES AND MEDICATIONS. Though all clinics stated that they do dispense medications on site, five clinics (21%) said they had run out of medications and/or supplies "often" in the past three months, and another 10 clinics (42%) said they had run out "sometimes" in the past three months. When asked what types of medications and supplies they had run out of, medications were most typically cited (13 or 87% of sample), but vaccines (4), laboratory supplies (3), medical supplies (5), office supplies (6), cleaning supplies (3), and educational materials (3) were also mentioned.

One significant service asset of the clinics is their dispensing of all medications typically prescribed for a child on site and at no charge. When the clinic does not have a medication, the child's parent/caregiver must either take a prescription to a pharmacy and pay for the medication, go to another clinic or hospital where the medication can be obtained free of charge, or return to the clinic when it restocks the medication. While there is no one correct procedure for stocking supplies, the fact that so many clinics run out of medications presents a serious problem, and may result in a child's failing to receive a needed medication. This study did not examine the process of obtaining medications and supplies, although anecdotally the problems seemed to be with obtaining them from the HHC networks rather than with clinic staff being remiss in tracking within individual clinics or in ordering.

- **RECOMMENDATION:** Develop a reliable mechanism to ensure that all outpatient and ambulatory clinics that dispense medications and use laboratory, office, and other supplies are able to maintain sufficient supplies on site at all times. The HHC Office of Child Health should survey the clinics to identify problems in the distribution of medications and supplies, and should monitor each network quarterly to ensure that medications and supplies are continuously available to patients and clinic staff so that clinic functions are not impaired and children are not at risk of going without needed medications.

MANY CLINICS DO NOT MAKE HOME VISITS. Only 63% (15) of the clinics said that they make home visits. This service is part of the public health "scope of services" described in the clinic transfer contract between HHC and DOH. Those that make home visits stated that it was to provide health care in an urgent situation, to follow up on a missed appointment, to follow up on abnormal lab results where the family could not be contacted by telephone, or to evaluate living and safety conditions, particularly if a child had been injured in the home or fallen out of a window. Staff at the nine clinics that did not make home visits said that they had been told that it was no longer allowed, either after the transfer of the clinics from DOH in 1994, or after the integration of the clinic into the network. Only 4 (17%) clinics said staff would make a home visit as a last resort to follow up with a child who had missed appointments, which is of concern to CCC, since not every family can be contacted by telephone. DOH makes home visits after a child in a household falls out of a window, when a child has tested as having a high lead level, and when there is an individual with tuberculosis in the home, and some clinics refer families to DOH for these services when indicated. However, not only are home visits

appropriate under a number of other circumstances, but the DOH/HHC contract states that HHC can not change the services offered in the clinics without written approval from DOH.[48]

- **RECOMMENDATION:** Require staff in every clinic to make home visits when it is appropriate in the judgment of clinic professional staff, for example, to find a child who has missed appointments when his/her family is not reachable by telephone, or to evaluate a child's environment for health risks. These visits can be made by clinic public health nurses or by public health nurses from a Certified Home Health Agency. Develop guidelines for public health nursing that include making home visits and promulgate them to all the clinics. Develop and promulgate a protocol regarding appropriate referrals to DOH for home visits for window falls, lead abatement, and tuberculosis cases.

STAFF MEMBERS IN MOST CLINICS RECEIVE ONGOING TRAINING, BUT TRAINING CURRICULA VARY BY CLINIC AND FEW ARE DEVOTED TO PEDIATRIC TREATMENT AND CLINICAL ISSUES.[49] Staff at three clinics (all in the same network) stated that no training of any kind had been offered to them in the three months preceding the study. In 17 (74%) of the clinics, all personnel, including administrative staff, had been trained in an asthma management program, leaving seven clinics where some staff members were not trained. The list of training topics recited to Task Force members by clinic staff included: cardiopulmonary resuscitation (CPR), computer systems, domestic violence, sexual harassment, infection control, fire safety, financial counseling, multicultural issues, managed care, asthma, hazardous waste, EKGs/defibrillators, tuberculosis, child development, risk management, patient relations, medical record documentation, stress management, child abuse and neglect, trauma, conflict resolution, and drawing blood. CPR, sexual harassment, customer relations, fire safety, and infection/infectious disease were the most often cited topics of training sessions. Clinic staff cited few training sessions regarding treatment and clinical concerns in child health. The above listed topics were not offered in all the networks, nor was there any consistency in the types of training offered to clinic staff. It was also not clear from responses to the study that the clinics that have expanded services to adolescents have trained staff specifically in adolescent issues and to provide reproductive health care.

- **RECOMMENDATION:** Ensure that clinic staff, both clinical and, when appropriate, administrative, receive regular training in up-to-date pediatric primary care clinical procedures and health education concerns, such as child development, adolescent primary care and reproductive health services, and asthma management. Contract with DOH for staff training on public health issues.

CLINICS DO NOT HAVE UNIFORM PROTOCOLS TO REFER FAMILIES FOR SOCIAL SERVICES OR PUBLIC BENEFITS. When asked where they refer families that need assistance in accessing social services, 13 (54%) said that they refer to the HHC network, and 6 (25%) said they refer to the New York City Human Resources Administration (HRA). While it was not clear from these responses whether or not the referral sources are beneficial to families, the fact is that a referral to HRA will only be helpful if the family is in need of public benefits, such as Temporary Assistance to Needy Families (TANF) or housing assistance, or emergency benefits. The study did not ask about the training of the public health nurses in the clinics

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48 The contract's Scope of Services states that the clinics will make home visits as part of "Public Health Efforts" to respond to Sudden Infant Death Syndrome and window falls, although it does not preclude them for other reasons. Source: Annex A of DOH/HHC contract: Bureau of Child Health Scope of Services.

49 The Central Office for Child Health at HHC hired a Director for its Public Health Education Unit in February 1999, after CCC had completed its study. A calendar of training topics from August through October 1999 showed that the Central Office is providing training to clinic staff in lead poisoning preventions and management, immunizations, public health nursing practices, teenage suicide and depression, and window falls prevention and reporting.

regarding these referrals, though it is the clinic nurses who make daily decisions on referring families for social services and other needs not met in the clinics.

- **RECOMMENDATION:** Ensure that every nurse in each clinic is fully trained to assess the needs of children and their families for social services and public benefits and to make appropriate referrals. Referrals should be made for families seeking information and/or needing help with housing, public assistance, behavioral and developmental problems, referrals to the Early Intervention program, and parenting, and other topics. Many families served by the clinics are likely at some point to need information and assistance with other types of services; the clinics should be a reliable referral source.

NOT ALL CLINICS DO LAB WORK ON SITE. One quarter (6) of the clinics do not complete lab work on site. All but one of the clinics surveyed employed a lab assistant to take samples, even for tests where the lab work will not be completed on site. Regardless of how the clinic obtains samples and where they are tested, an inability to provide results quickly can be an inconvenience for families by requiring them to make another visit to get test results and receive information and education for treatment and follow-up. For example, a child with anemia should increase his/her iron intake immediately – delays in getting test results can negatively impact the child's health status.

- **RECOMMENDATION:** Ensure that children and families have access to results of lab tests within a reasonable period of time. These results should include the hematocrit (for anemia) and the rapid strep test.

FEW CLINICS HAVE READING PROGRAMS OR DISTRIBUTE READING MATERIALS. Only 7 clinics (29%) had "Reach Out and Read" (5 clinics) or distributed books to children in the waiting room (2 clinics). "Reach Out and Read" is a literacy program that integrates reading into the child's time in the waiting room and visit with the doctor, and sends the child home with an age-appropriate book given to him/her by the doctor.

- **RECOMMENDATION:** Coordinate efforts to put the "Reach Out and Read" program in every clinic (or a range of age-appropriate reading material in every clinic waiting room). This initiative will assist the clinics in their efforts to educate and work with families on child development.

Clinic Enrollment and Utilization

A LACK OF DOCUMENTATION DOES NOT PREVENT A CHILD FROM ENROLLING IN A CLINIC FOR CARE. Staff at 15 clinics (63%) said they ask for some form of documentation but will provide services to the child without it, and staff at 4 clinics (17%) said they ask for proof of guardianship in order to establish that the adult with a child is in fact that child's guardian. Clinics will also provide services to children regardless of whether or not they enroll in the clinic for ongoing primary care. Each clinic reported having seen at least 50 children in the past year for a school or day care health examination, but not all of these children were regularly enrolled in the clinic for primary care. Most respondents estimated that the great majority of children seen for these exams were enrolled in the clinic, but staff in 11 clinics estimated that between 40% and 80% were enrolled in the clinic. From this finding it is clear that the clinics continue to be available for public health and preventive services, even for children who have another regular source of health care or whose parents/caregivers for some reason do not wish to enroll them for primary care at the clinic.

Children who present at a clinic are seen and treated, though occasionally a child's illness requires emergency room care. Seventeen (71%) of clinics surveyed said they had sent fewer than five children to a hospital emergency room in the month prior to the survey.

TWENTY-TWO (92%) OF THE CLINICS REPORTED THAT A CHILD WHO WALKS INTO A CLINIC OR WHOSE PARENT/CAREGIVER CALLS FOR AN IMMUNIZATION CAN "ALWAYS" OR "USUALLY" BE SEEN THE SAME DAY TO GET THAT IMMUNIZATION. Two clinics said that a child who calls or walks in for an immunization could "sometimes"

get it the same day. All the clinics said that they would immunize a child who is not enrolled for primary care.

CLINICS TRACK APPOINTMENTS AND SCHEDULE REGULAR CHECK-UPS. All clinics had protocols for ensuring that children who missed appointments were rescheduled and that all children enrolled were up-to-date on their regular check-ups. All the clinics felt that they were very effective in ensuring that all enrolled children received their regular check-ups.

MANAGED CARE PLAN ENROLLMENT COMPLICATES PROVISION OF CARE. When our survey asked about the existence of obstacles to providing care, the single issue raised by study respondents was that of children coming for treatment who are enrolled with a managed care plan where the clinic is not the child's designated primary care provider. Thirty percent (7) of clinics surveyed said that this was a concern for them. Continuity of care for these children may be threatened in these situations, and HHC risks not receiving payment for services provided by the clinic. Clinics had a range of procedures for managing these situations. Some clinics treated the child with only a recommendation to the family to go to the child's primary care doctor the next time. Some tried calling the primary care doctor and scheduling an appointment for the child, then treating the child if he/she was ill. In one network, clinics were told to treat the child and ask the family to call the managed care plan and have the primary care provider changed to the clinic itself, a solution only if the HHC network was already affiliated with the child's managed care plan.

- **RECOMMENDATION:** Clarify and educate clinic staff members regarding HHC policy in situations where children enrolled with another primary care provider present at a clinic for primary care, including check-ups, immunizations, treatment of an illness, or other services, with the goal of ensuring that no child goes without needed health care services. This effort will become more crucial as both Medicaid and Child Health Plus managed care plan enrollment grows.

CLINICS MAY BE UNDERUTILIZED. Information collected by CCC Task Force members during site visits provided indications of utilization declines at several clinics. In five (21%) of the 24 clinics visited, Task Force members were unable to interview parents/caregivers because the clinics were empty – only staff were present. While it may be that the absence of patients was due to the time of day of the visit or some other issue of timing, it happened often enough to raise concern. In an additional 8 clinics (33%), staff expressed concerns to Task Force members about utilization declines or about the clinic's ability to conduct outreach. In fact, HHC data show a 23% decline between City Fiscal Years 1993 and 1998 in the number of patients served at the clinics (the number of users declined from 100,331 to 77,736).[50] During the same period, four Child Health Clinics closed permanently, and three Child Health Clinics were converted to Communicare sites, which contributed significantly to the drop in the number of children served. This drop in utilization may have leveled off, since the number of patients served between FY 1997 and FY 1998 did not decline: in 1997, the Child Health Clinics served 78,439 children; in 1998, 77,736 children were served and during that year approximately ten sites were closed or temporarily consolidated for all or part of the year for renovations or repairs.

[50] See Appendix G for all HHC utilitzation data cited in this paragraph and following chart.

CHILDREN SERVED

NETWORK	FY'93	FY'98	% CHANGE
North Bronx	10,640	8,710	-18.1%
Generations Plus	9,248	8,454	-8.6%
North Manhattan	9,335	8,075	-13.5%
South Manhattan	4,054	1,383	-65.9%
Queens	19,497	15,385	-22.9%
Brooklyn North	21,536	17,314	-19.6%
Bklyn S./SI	14,774	13,057	-11.6%
Coney Island	6,069	5,358	-11.7%
Clinics Closed*	5,178	0	100.0%
TOTAL	**100,331**	**77,736**	**-22.9%**

* Clinics were permanently closed in Generations Plus (South Bronx and East Harlem), and Brooklyn South/Staten Island. Clinics were converted to Communicare in North Manhattan, South Manhattan, and Brooklyn South/Staten Island.

While the number of clinical visits stayed about the same for FY 1997 and FY 1998, the number of visits for public health purposes declined 19% (from 58,596 to 47,461).[51] Public health visits, which are provided by trained public health nurses in the clinics, are often one-time visits with children not enrolled in the clinic for ongoing care, or can be a non-insurance billable service provided to a child who is enrolled in the clinic. Typical public health visits are for reading and explaining laboratory test results, providing lead screenings, giving immunizations, and educating children and families about health issues. These services are not typically available to children without insurance coverage in other primary care settings. HHC is analyzing reasons for the decrease in the number of reported public health visits, which it feels may be due to changes in data reporting and collection practices as a result of the integration of the clinics into the HHC network structure.

Several reasons were given by clinic staff for declines in the number of clinic visits by children: when clinics re-open after having been closed for renovations (most clinics have had them or need them), they lose patients to other health care facilities, including other HHC facilities; and renovated and recently opened facilities in many cases have attempted little outreach or marketing on behalf of the clinic in the community to attract patients. It was not possible for CCC to draw conclusions regarding reasons for declines in clinic visits, except in the clear instance of clinic closures and conversions of Child Health Clinics to Communicare clinics.[52]

- **RECOMMENDATION:** Conduct a major outreach effort to promote the services of the Child Health and Communicare clinics with the goal of ensuring that all New York City children without a source of quality primary care be enrolled at a Child Health or Communicare clinic. Target specific populations with large proportions of children lacking regular primary care providers, such as children in foster care, adolescents, recent immigrants, children currently served in the Department of Health's School Examination Clinics,[53] babies born at home, and children living in close proximity to clinics. In addition, ensure that all HHC hospitals refer all newborns in need of primary care services to a clinic in a convenient location. As part of this effort, analyze utilization data by clinic and network to determine clinic utilization patterns and why clinic utilization citywide has decreased.

CLINICS COULD BE A SOURCE OF HEALTH CARE FOR MORE CHILDREN IN FOSTER CARE. Clinics do not collect information from children and families regarding foster care status. CCC's study asked clinic staff how many children served at each clinic were in foster care, but clinic staff members could not respond to the question. Information from other sources indicates that many foster children have significant unmet health needs and that their access to regular primary care is often

51 Source for HHC data: HHC Office of Child Health, 9/99.

52 See Appendix G for HHC utilization data.

53 The School Examination Clinics, which provide annual school examinations to 15,000 children a year, are slated for closure. The City Department of Health will have the task of ensuring that all children seen in the School Examination Clinics are referred to primary care providers.

compromised.[54] Given concerns regarding overall accessibility of health care to foster children and efforts by the New York City Administration for Children's Services (ACS) to ensure that foster children receive primary care, the clinics could be a significant resource for primary care services to them.

- **RECOMMENDATION:** Maximize utilization of clinic services by New York City children in foster care without primary care providers by creating a mechanism for ACS and voluntary foster care agencies to refer children to the clinics for primary care services. Ensure that every clinic becomes part of the ACS preferred provider list currently in development.

Physical Plant

PHYSICAL PLANTS VARIED GREATLY; SOME CLINICS HAD SIGNIFICANT EQUIPMENT AND STRUCTURAL PROBLEMS. Seven of the clinics were particularly run down and bare. Eleven clinics looked recently renovated or painted and inviting to patients and family members. DOH and HHC have both made capital investments in a number of clinics in recent years, and all the Communicare clinics surveyed were recently opened and in excellent condition. However, some Child Health Clinics were in very poor physical condition.

When asked if the clinic had experienced physical plant problems in the past three months, staff at 3 clinics (13%) said they had them "often," and staff at 15 clinics (63%) said "sometimes." The physical plant problems consisted mostly of lack of heat (7 clinics), telephone problems (5 clinics), and leaks or plumbing problems (7 clinics). Of all physical plant problems, a lack of working telephones had the greatest negative impact on the day-to-day operations of clinics. Of the 24 clinics CCC surveyed, 14 were in buildings owned by DOH, 8 were in New York City Housing Authority ("NYCHA") buildings (public housing), and 2 clinics were in buildings under private ownership. Buildings owned by DOH and NYCHA were equally likely to have serious physical plant problems.

Most clinic staff said it took a single day or less than a week to fix physical plant problems, but five clinics (5 of 18 with physical plant problems – 28%) said that problems had not been fixed. Examples of problems that had not been fixed included: water leaks (cited by 4 clinics); mice infestations; rotary telephone systems and problems with telephone lines; lack of storage; windows that would not open; windows that would not close; heat and air conditioning problems; and peeling paint and plaster. Additionally, 35% (8 of 23) of the clinics were not clearly identified on the outside of the building, and 29% (7 of 24) of the clinics had neither a working entrance buzzer nor a security guard. These problems not only make it difficult to maintain clinic operations but can also compromise patient and staff safety.

A number of clinics have benefited from the installation of modern technology as a result of integration into HHC networks. While some clinics are limited in functioning by rotary telephones and no computers, others have modern telephones for the first time, and are being wired into network computer systems that will eventually allow them to check laboratory test status and make appointments with other HHC facilities.

- **RECOMMENDATION:** Ensure that all clinics in need of capital improvements and renovations are part of capital investment plans and that those plans are executed and are monitored centrally by HHC, whether the owner of the facility is DOH, NYCHA, or a private landlord.

TOO MANY CLINICS LACK FURNITURE, EQUIPMENT, AND EDUCATIONAL MATERIALS APPROPRIATE FOR CHILDREN. Fifty-nine percent (13 of 22) of the clinics did not have games and/or books appropriate for children in the waiting room. Fifty percent of the clinics (11 of 22) did not have furniture and equipment appropriately sized for children.

54 Dicker, S. and Blatt, S. July 1999. "*Advocating for the Health of Children in Foster Care.*" New York: Permanent Judicial Commission on Justice for Children.

- **RECOMMENDATION:** Evaluate equipment needs of all the clinics and work with HHC networks to direct additional resources to those clinics in need of capital improvements, code compliance efforts, child and adolescent-appropriate furnishings and equipment, and upgraded telephones and computer systems. Ensure that major structural and equipment problems are addressed in all the clinics. Allow the clinics to benefit from network computer systems for appointments, patient records, and lab test results by fully integrating the clinics into these systems.

Insurance Coverage and Patient Fees

Under current HHC policy, clinics cannot charge families for services rendered, but if the child has health insurance coverage, the clinics can bill Medicaid or Child Health Plus, a policy that CCC supports. Clinics can also encourage the family of an insurance-eligible child to enroll him or her, but families lack an incentive to enroll an uninsured child unless they need to or want to take the child elsewhere for specialty care or services.

MOST CLINICS PROVIDE SOME ASSISTANCE WITH SECURING INSURANCE COVERAGE. Financial counselors meet with the families of uninsured children in 71% (17) of the clinics to assist families with applying for Medicaid and Child Health Plus. However, 6 of the 18 had a financial counselor in the clinic only once each week or only referred parents to a financial counselor at another HHC facility.[55] Anecdotally, some clinic staff members were certain that the family of every uninsured child seen at the clinic did eventually meet with a financial counselor; however, it was not clear from the study that the availability of a financial counselor meant that all uninsured children were given an opportunity to enroll in an insurance program. It is also important to note that 10 of the 18 parents (of 36 interviewed) who said that their child was uninsured also said that they had met with a financial counselor.

- **RECOMMENDATION:** Ensure that a financial counselor is available on site at least part-time in every clinic to enroll eligible children in Medicaid and Child Health Plus. Ensure that every family of an uninsured child seen meets with a counselor at the clinic and is encouraged to enroll their child and that the counselor assists the family through the enrollment process. These financial counselors must be trained to assist families in filling out forms and completing the enrollment process, as well as to provide information and referrals for Child Health Plus, Medicaid, and Medicaid Managed Care.

NO FEES ARE CHARGED TO PROVIDE SERVICES TO UNINSURED CHILDREN. The clinics surveyed, with one exception (a Communicare clinic), reported that they do not charge families for services to children of any type. One priority of the HHC central administration has been that the clinics continue to provide free services to those children without insurance even after the integration of the clinics into HHC networks. While HHC has service fee scales in its other facilities, Corporation policy is that the Child Health Clinics continue to provide services at no charge. (Communicare clinics have a sliding scale fee schedule for non-pediatric visits.) These payment policies were intended to preserve access to care in the clinics, which have historically served children who had few options for primary care.

- **RECOMMENDATION:** Monitor all Child Health and Communicare clinics to ensure compliance with HHC policy of not charging for clinic services to uninsured children and adolescents.
- **RECOMMENDATION:** Work with the Division of Health Care Access at DOH, assess the impact of eligibility expansions in Medicaid and Child Health Plus on the populations of children served by the clinics and use this information to develop a plan to maximize health insurance enrollment in the clinics.[56]

55 "Financial counselor" is the term used by HHC to denote an individual who provides education regarding insurance options and facilitates a child's enrollment in an insurance program.

- **RECOMMENDATION:** Educate all Child Health staff regarding HHC's process for tracking insured children and billing insurance companies for services, including managed care plans, and regarding the impact of insurance enrollment on the clinics' finances. Federal Community Health Partnership funds allocated by HHC to train its employees about managed care could be used for this purpose. A lack of familiarity with managed care and methods of payment for services can be an obstacle to enrolling eligible children in insurance programs and to HHC's maximizing its ability to bill for services provided to children in the clinics.

HHC and DOH Management and Oversight

SYSTEM OVERSIGHT AND PLANNING NEEDS STRENGTHENING. While this study focused on policies and procedures at the clinics and not on the operations of the HHC administration, it was clear from some findings in this study that essential systemwide initiatives on behalf of the clinics need support from the HHC central administration. One example of this is the lack of a uniform policy in the clinics around home visits, even though this service was specifically mentioned in the scope of services of the DOH/HHC contract that expired in 1998. Another example of an initiative that needs systemwide support is the education of families regarding health insurance and enrollment of children in Medicaid and Child Health Plus. Individual clinic practices varied widely from full-time assistance on site with filling out applications, to no on-site assistance or education other than making brochures available. Whether or not eligible children enroll in insurance programs is of such importance to HHC, both because of its impact on the provision of care and for HHC's long-term financial viability, that it deserves systemwide attention and support.

The Office for Child Health can also play a significant role in helping the clinics interact with other government agencies and systems, for example to ensure that clinics continue to collaborate with DOH to address public health and community health concerns. In addition, CCC's findings indicate that staff training is not being supported to the extent necessary to ensure continued quality care. The lack of clinically-focused training for clinic staff, and particularly the fact that staff in 7 clinics had not all received training in asthma management, indicates that this is a concern for HHC overall.

Finally, a number of Child Health Clinics surveyed indicated that they had significant physical plant problems, and since this study was completed, it has come to CCC's attention that two clinics in the South Bronx have been closed indefinitely due to physical plant problems that must be addressed by HHC and NYCHA, which houses the two clinics. It is clear that the Office of Child Health must work to ensure that needed renovations are completed in a timely fashion, even if the actual work is the responsibility of DOH or NYCHA.

- **RECOMMENDATION:** Strengthen the Office for Child Health to allow it to plan for pediatric services citywide in the following ways:
  - Assessing unmet need for pediatric primary care services by neighborhood, in order to plan for potential additional services in and locations of clinics;
  - Assisting facilities with identifying strategies to promote Child Health Plus and Medicaid enrollment;
  - Replicating the medical home model used in the clinics in ambulatory care divisions in other HHC facilities;
  - Developing and publicizing prevention and education campaigns for HHC around specific child health needs such as lead poisoning, asthma, and child development;

56 The recently created Division of Health Care Access is charged with the mission of promoting "the availability of quality health care services in New York City through Medicaid Managed Care and other insurance programs" and will plan and support programs that promote this mission. Source: DOH Mission Statement. www.ci.nyc.ny.us/html/doh/home.html.

- Assisting networks with developing and disseminating educational and screening materials for child specific neighborhood health fairs; and
- Recruiting parents/caregivers of clinic patients for membership on HHC Community Advisory Boards to reflect the needs of clinic patients in the community advisory process.
- Ensure that the Office of Child Health has access to the resources needed to fulfill all these functions.

RESPONSES TO QUESTIONS IN ON-SITE INTERVIEWS AT CLINICS SHOWED WIDE VARIATIONS AMONG THE HHC NETWORKS IN POLICIES AND PROCEDURES AFFECTING CLINIC OPERATIONS. While the data from the site visits was not conclusive, it was CCC's strong sense that the Generations Plus (South Bronx and East Harlem) network in particular and the Coney Island network to a lesser degree need stronger management support and oversight. To give a few examples, clinics in these networks were more likely than clinics in other networks to report that they did not make home visits, did not have access to regular staff training, and did not assist families in completing applications for Child Health Plus and Medicaid. An unusually large proportion of clinics in the Generations Plus network have also experienced physical plant problems that have led to their temporary closure, in two cases for many months. For the most part, however, the problems identified in the study were present in clinics all across the City.

- **RECOMMENDATION:** Ensure that every network has appropriate supervision and, when needed, technical assistance from the HHC central administration, and that policies in every network are uniform and in accordance with the DOH/HHC Transfer Agreement.

DOH OVERSIGHT OF THE CLINICS MUST CONTINUE. DOH contracts with HHC to operate the Child Health Clinics and has oversight of the clinics, as described in the "Context for The Study." Under this contract, HHC is required to conform to a specific scope of services and can not make changes to those services without authorization from DOH. In at least one area, home visits, study data indicated that some clinics are not conforming to the scope of services. In addition to providing oversight, DOH can also provide important information for HHC to use in planning for the clinics. CCC makes the following recommendations to DOH in its oversight role:

- **RECOMMENDATION:** Ensure that the Child Health and Communicare clinics continue to provide the full scope of services as described in the DOH/HHC Transfer Agreement.
- **RECOMMENDATION:** Continue to make announced and unannounced site visits to clinics as defined in the Transfer Agreement to ensure that clinics are operating according to the agreement.
- **RECOMMENDATION:** Through the DOH Division of Health Care Access, work with HHC to assess the impact of eligibility expansions in Medicaid and Child Health Plus on the populations of children served by the clinics. With HHC, use this information to develop a plan to maximize health insurance enrollment in the clinics.

Conclusion

CCC's study examined whether HHC is maintaining oversight of the clinics' dual public health and primary care missions while maintaining high quality and open access for low-income and immigrant children, regardless of their insurance status. Findings from CCC's study of nineteen Child Health Clinics and five pediatric divisions of Communicare clinics operated by all seven of the HHC networks lead to the conclusion that HHC is fulfilling the clinics' mission to provide primary care and public health services to children and that administrative transitions within HHC have not prevented the clinics from providing these services. There are, however, some lapses in oversight and operations that may threaten their continued ability to do so. HHC's ability to plan child health services must be strengthened to ensure that the clinics continue to provide high quality services to children in need of a primary care provider.

The Child Health Clinics provide a crucial link to primary care services for uninsured and immigrant children, but also are an important source of primary care for children insured by Medicaid and Child Health Plus managed care plans. For both New York City's insured and uninsured children, the clinics are a source of high quality health care, making CCC's recommendations to invest in the physical and operational infrastructure of the Clinics investments that will benefit New York City's children. CCC will continue its advocacy by working with the Health and Hospitals Corporation and the New York City Department of Health to implement these recommendations and to support the clinics so that they can continue to provide high quality primary health care and public health services to all New York City children who need them.

Appendices

A. FIELD STUDY QUESTIONNAIRE

B. TABLE OF SELECTED DATA

C. TASK FORCE MEMBERS

D. LISTING OF CLINICS

E. MAP OF CHILD HEALTH CLINICS AND COMMUNICARE CLINIC SITES

F. MAP OF OTHER PUBLICLY-SUPPORTED PRIMARY CARE SERVICES TO CHILDREN

G. CHILD HEALTH CLINICS USERS – FY'93 THROUGH FY'98 AND CHILD HEALTH CLINICS VISITS – FY'97 AND FY'98 (HHC DOCUMENTS)

Appendix A: Field Study Questionnaire

Citizens' Committee for Children of New York

SITE VISIT QUESTIONNAIRE

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
CHILD HEALTH CLINICS

This questionnaire is to be completed by the CCC volunteers making the site visit. Please complete one questionnaire for every site and send to Suri Duitch by fax (212) 979-5063 or by mail, CCC, 105 E. 22nd St., NY, NY 10010, by February 19, 1999. Please review this questionnaire prior to making your site visit. Please note that there is space for comments after each question.

Please introduce yourself to the staff at the Clinic and give them the following information about CCC: CCC is a child advocacy organization that has been advocating for New York City's children for 54 years in the areas of health, mental health, child welfare, housing, child care, education, income support, and youth services. We are making site visits to 20 Child Health Clinics and 3 Communicare clinics across New York City as part of a study of the Child Health Clinics and their role in providing primary health care and public health services to New York City children. Information collected during this site visit will be used in the study and in CCC's advocacy efforts on behalf of the Clinics, however, **no administrator, staff person, or patient will be identified by name in any CCC publication or advocacy efforts.**

GENERAL INFORMATION

Name of Clinic: _____ Date and Time of Clinic Visit:

This Clinic is a (check one):
❑*Child Health Clinic* ❑*Communicare clinic (Pediatric services)*

Name and Title of Clinic Representative: _____

Address: _____

Phone: _____ Hours of operation: _____

Name of CCC Volunteer(s) completing questionnaire: _____

1. Total number of staff assigned to this clinic: _____

Title (please list each staff person by title)	*# of hours working at this clinic*	*rotates to other HHC facilities as part of primary Child Health Clinic assignment? (y/n)*

2. What type(s) of identification or documentation are required for a child to be enrolled at this clinic? (check all that apply)

- ❑ Birth certificate
- ❑ Driver's license/identification card
- ❑ Insurance card/Medicaid card
- ❑ Utility bill/Proof of address
- ❑ Social Security card
- ❑ None required
- ❑ Immunization record
- ❑ Other (please describe):

3. How many staff at this clinic are bilingual?
Support staff: _____ Professional staff _____
What languages are spoken by staff at this clinic?

4. What neighborhoods are this clinic's patients from? _____

5. What age range of children are served at this clinic? _____

PRIMARY CARE

6. What services are regularly offered to children at this clinic? Check all that apply.

Preventive Care/Screenings:

- ❑ Routine check-ups
- ❑ Child/Teen Health Plan (C/THP)/ Early Periodic Screening Diagnosis and Treatment (EPSDT) visits
- ❑ Immunizations
- ❑ Hearing screenings
- ❑ Vision screenings
- ❑ Developmental assessments
- ❑ Indicated Denver developmental screenings
- ❑ Anticipatory guidance
- ❑ Lead poisoning screenings
- ❑ School/activity registration examinations
- ❑ Medical examinations for children who have been abused or neglected
- ❑ Other(s) (please describe):

Treatment:

- ❑ Respiratory illness
- ❑ Ear infection
- ❑ Lead poisoning treatment
- ❑ Infant health care concerns
- ❑ All routine illnesses
- ❑ Other(s) (please describe):

7. On average, how many children are seen at this clinic every month?
   ❑ Fewer than 75 ❑ 75-150 ❑ 150-250 ❑ 250 +

   Approximately how many children has this clinic referred to the emergency room in the past month?
   ❑ Fewer than 5 ❑ 10 – 20
   ❑ 5 – 10 ❑ More than 20

   For what types of problems were these children referred to the emergency room?
   ❑ Fever ❑ Ear infection
   ❑ Stomach ache ❑ Accidents/injuries
   ❑ Other (please describe):

8. What method does this clinic use to make sure that children complete C/THP/EPSDT components?

9. Do staff members at this clinic make home visits? ❑ Yes ❑ No

   If yes, how many home visits do staff members make each month in total?_____

10. For what reasons do staff members make home visits?
   ❑ Routine assessment
   ❑ Urgent care
   ❑ Family cannot travel to clinic-one time basis
   ❑ Family cannot travel to clinic-regularly
   ❑ Follow up with missed appointment
   ❑ Not applicable – do not make home visits
   ❑ Other (please describe)

11. How does this clinic follow up with children who miss appointments or stop coming in for routine check-ups?
   ❑ Home visits
   ❑ Phone call
   ❑ Mail appointment card
   ❑ No follow up
   ❑ Other (please describe):

   If follow-up is done, which staff member is responsible for follow-up?
   ❑ Doctor ❑ Administrative staff
   ❑ Nurse ❑ Other (please describe)

12. Does a child see the same practitioner for all sick and well-child visits at this clinic? ❑ Yes ❑ No

13. Does this clinic have a procedure in place to refer a child who has failed a hearing screening for a full evaluation? ❑ Yes ❑ No

Where does this clinic refer a child who has failed a hearing screening?

What is the typical waiting time for a full evaluation?
❑ Less than 6 weeks ❑ 6 weeks – 3 months ❑ More than 3 months

14. Does this clinic have a procedure in place to refer a child who has failed a vision screening for a full evaluation? ❑ Yes ❑ No

Where does this clinic refer a child who has failed a vision screening?

What is the typical waiting time for a full evaluation?
❑ Less than 6 weeks ❑ 6 weeks – 3 months ❑ More than 3 months

15. Is lab work ever done on site at this clinic? ❑ Yes ❑ No
If no, where does this clinic send lab work?
If yes, please list types of lab work done on site:

16. Does this clinic dispense medications on site? ❑ Yes ❑ No

17. Has this clinic run out of any pharmaceuticals or supplies within the past three months?
❑ Often ❑ Sometimes ❑ Never

If often or sometimes, what types of pharmaceuticals or supplies did this clinic run out of ?
(Check all that apply)
❑ Vaccines
❑ Medications
❑ Laboratory supplies
❑ Formulary inventory
❑ Medical supplies
❑ Office supplies
❑ Educational materials
❑ Other (Please explain):

18. Who do you call when you run out of or have problems with pharmaceuticals or supplies?
❑ Network Administrator ❑ Supply company
❑ HHC Representative ❑ Unsure
❑ Other (please describe):

19. What type(s) of transportation assistance does this clinic provide for patients? (check all that apply)

- ❑ Tokens/Metrocard
- ❑ Money for carfare
- ❑ Other (please describe):
- ❑ Shuttle to HHC facility
- ❑ None

PUBLIC HEALTH

20. Can a child who calls or walks-in for an immunization get it the same day?

❑ Always ❑ Usually ❑ Sometimes ❑ Never

21. Does this clinic provide immunizations for children not enrolled in the clinic for primary care? ❑ Yes ❑ No

22. Is each staff member (including administrative staff) in this clinic trained in an asthma management program? ❑ Yes ❑ No

23. In the past six months, approximately how many children in foster care have been seen in this clinic for primary care?

❑ Less than 5 ❑ 5-10 ❑ 11-20 ❑ More than 20
❑ Unsure

24. Approximately how many children per year come to this clinic specifically for check-ups and/or immunizations that are required for day care or school entry?

❑ Less than 10 ❑ 10 – 25 ❑ 25 – 50 ❑ More than 50

Approximately what portion of these children are enrolled in this clinic for ongoing primary care?

❑ 100% – 80% ❑ 80% – 60 % ❑ 60% – 40% ❑ 40% – 20% ❑ less than 20 %

25. Regarding which of the following issues does this clinic provide education to children and families? (check all that apply)

- ❑ Lead exposure
- ❑ Asthma management
- ❑ Nutrition
- ❑ Tuberculosis
- ❑ Reach Out and Read
- ❑ Child Development
- ❑ Injury prevention
- ❑ HIV/AIDS
- ❑ Sickle Cell Anemia
- ❑ TV watching
- ❑ Gun safety
- ❑ Other (please describe):

26. Does this clinic have a "Reach Out and Read" program or distribute books to children in the waiting room? ❑ Yes ❑ No

If yes, where does this clinic get these books?
❑ HHC Network ❑ Other (please describe):

27. Regarding which of the following issues does this clinic make referrals for children and families? (check all that apply)
❑ Health care for older siblings, parents, and other family members
❑ Mental health assessments and services
❑ Specialty care for chronic problems
❑ Public Assistance/Welfare
❑ Housing assistance
❑ Nutritional assistance
❑ Early intervention/Early childhood programs (Headstart, Pre-Kindergarten)
❑ Other (please describe):

28. If a family needs social service assistance, what referral source does this clinic use?
❑ HHC Network offices
❑ No source
❑ Other (please describe)
❑ Human Resources Administration Income Maintenance Office/Job Center

29. In the past six months, has this clinic collaborated with the City Health Department to address a public health or community health concern? ❑ Yes ❑ No

If yes, what was the nature of the concern?
❑ Asthma ❑ Hepatitis
❑ Measles ❑ Tuberculosis
❑ Lead poisoning ❑ Other (please describe):

30. Have there been any trainings for staff members of this clinic in the past 3 months? ❑ Yes ❑ No

If yes, where were the trainings?
❑ At this clinic ❑ At another HHC facility
❑ Other (please describe):

If yes, what were the topics of the trainings?

PAYMENT FOR SERVICES

Note for CCC volunteer: If you are visiting a Communicare site, ask questions in this section about Pediatric Communicare only, not about the entire clinic, which also serves adults.

31. Are patients required to pay for services at this clinic? ❑ Yes ❑ No

If yes, in what format(s)? (check all that apply)
- ❑ Insurance co-payment
- ❑ Sliding scale
- ❑ Fee for service rate schedule
- ❑ Other (please describe):

32. Does this clinic bill insurance companies or Medicaid for services provided to children? ❑ Yes ❑ No

33. Does this clinic face any barriers in providing health care to children who are:

Uninsured	❑ Yes	❑ No
Legal immigrants	❑ Yes	❑ No
Undocumented immigrants	❑ Yes	❑ No
Living outside the neighborhood served	❑ Yes	❑ No
Assigned to a primary care provider other than this Child Health Clinic	❑ Yes	❑ No

If the answer to any of the above is yes, please describe:

34. Does a financial counselor meet with a family member when an uninsured child comes in for an appointment? ❑ Yes ❑ No

35. If yes, approximately what percentage of families of uninsured children meet with a financial counselor?
❑ 100% – 80% ❑ 80% – 60 % ❑ 60% – 40% ❑ 40% – 20% ❑ less than 20 %

36. At what point during the appointment does the family see a financial counselor?
- ❑ Prior to receiving services
- ❑ After receiving services
- ❑ Other (please describe):

37. Does this clinic assist children in applying for Medicaid or Child Health Plus on site? ❑ Yes ❑ No

38. If yes, in what ways does this clinic link potentially eligible children to Medicaid and Child Health Plus? (check all that apply)

Distribute brochure for Child Health Plus	❑ Yes	❑ No
Refer to Child Health Plus enrollment site	❑ Yes	❑ No
Refer to Medicaid enrollment sites	❑ Yes	❑ No
Assist family in filling out forms	❑ Yes	❑ No
Other method(s)	❑ Yes	❑ No

If other, please describe:

PHYSICAL PLANT

39. Who owns or manages your building?
- ❑ New York City Housing Authority (NYCHA)
- ❑ New York City Health and Hospitals Corporation (HHC)
- ❑ New York City Department of Health (DOH)
- ❑ Private owner
- ❑ Other (please describe):

40. Have you experienced physical plant problem(s) in this clinic in the past 3 months?
- ❑ Often ❑ Sometimes ❑ Never

If often or sometimes, what type(s)? (check all that apply)
- ❑ Electrical ❑ Equipment
- ❑ Telephone ❑ Other
- ❑ Structural

Please describe the problems:

41. Who do you contact regarding these problems?
- ❑ HHC Central Administration
- ❑ HHC Network Administrator
- ❑ Building Manager
- ❑ Other (please describe):

42. How long did it typically take for the problem(s) to be fixed?
- ❑ Less than 3 days ❑ 3 months
- ❑ Less than 1 week ❑ Not yet fixed
- ❑ 1 month

43. During evening and weekend hours, does this clinic utilize any extra security precautions?
- ❑ Yes ❑ No ❑ Not applicable

If yes, what type of security (check all that apply):
- ❑ Additional security guards ❑ Buzzer
- ❑ Outside lighting ❑ Sign-in with guard
- ❑ Other (please describe)

42

CONCLUSION

44. Please characterize the general operations of this clinic in the past six months:
❑ Excellent ❑ Good ❑ Fair ❑ Poor
Please elaborate:

Is there anything that you would like to tell us about this Clinic that we have not asked about?

QUESTIONS FOR CCC VOLUNTEER(S): Please answer the following questions based on your own observations:

45. Is this clinic clearly identified on the outside of the building? ❑ Yes ❑ No
Please describe:

46. Is there an operating buzzer or a security guard posted at this clinic? ❑ Yes ❑ No

47. Are the furniture and equipment child-size? ❑ Yes ❑ No

48. Are the furniture and equipment in good condition? ❑ Yes ❑ No

49. Are there games and books or other materials appropriate for children available while children are waiting for appointments? ❑ Yes ❑ No

50. Is the waiting room area clearly defined? ❑ Yes ❑ No

51. Is there sufficient seating for children and parents in the waiting room? ❑ Yes ❑ No

52. Are the exam rooms clean and orderly? ❑ Yes ❑ No

53. Do the exam rooms have doors that close? ❑ Yes ❑ No

54. Is there a working phone available to families at this clinic (either public telephone or signs posted allowing access to clinic phones if needed)? ❑ Yes ❑ No

55. Is the television in the waiting room running?
❑ Yes ❑ No ❑ No TV
If yes, what is showing?

telephone or signs posted allowing access to clinic phones if needed)? ❑ Yes ❑ No

55. Is the television in the waiting room running?
❑ Yes ❑ No ❑ No TV
If yes, what is showing?

56. Are the bathrooms clean and well maintained? ❑ Yes ❑ No

57. Please note any of the following:
❑ Water leaks ❑ Rusted equipment
❑ Water damage ❑ Cracked/broken windows
❑ Peeling paint ❑ Broken/inadequate lighting
❑ Floor damage
Please comment on physical appearance and condition of this clinic:

QUESTIONS FOR PARENTS/CAREGIVERS

Note to CCC Volunteer(s): If possible, address these questions to parent/caregivers(s) in 2 different families. There are separate pages for each family. Introduce yourself by saying the following:

I am here on a site visit for Citizens' Committee for Children, an organization that works to improve services to children and families in New York City. We are visiting 24 Child Health Clinics and Communicare clinics across the City to study how they are running, and we are talking to adult family members at each of those clinics. The information we collect will help us develop recommendations about how best to serve the children who come to the Clinics. Would you be willing to answer a few questions for our study?

58. Does your child have health insurance coverage? ❑ Yes ❑ No
If yes, what type of insurance does your child have?
❑ Medicaid
❑ Child Health Plus (CHP)
❑ Private
❑ Unsure

59. Does this insurance pay for your child's health care at this clinic?
❑ Yes ❑ No ❑ Unsure

60. Have you ever met with a financial counselor at this clinic to talk about insurance and/or payment?
❑ Yes ❑ No ❑ Unsure

61. Are you ever asked to pay for your child to receive services at this clinic?

❑ Yes ❑ No

If yes, when were you last asked to pay for services?
❑ More than one year ago
❑ Within the past year
❑ Within the past three (3) months

62. Do you call for an appointment at this clinic or walk-in to this clinic when your child needs to be seen?
❑ I always make an appointment
❑ I usually make an appointment
❑ I make an appointment about as often as I walk-in
❑ I usually walk-in
❑ I always walk-in

63. When you call ahead for routine care, about how long do you have to wait for an available appointment?
❑ Less than 3 days ❑ 3-7 days ❑ 7-14 days ❑ More than 2 weeks

64. Once at this clinic, about how long does your child wait to see a doctor or a nurse for medical care:
a. For walk-ins?
❑ Less than 15 minutes ❑ 30-60 minutes
❑ 15-30 minutes ❑ More than one hour
b. For appointments?
❑ Less than 15 minutes ❑ 30-60 minutes
❑ 15-30 minutes ❑ More than one hour

65. How long have you been bringing your child(ren) to the Child Health Clinic or Communicare clinic for medical care?
❑ First visit ❑ Less than six months ❑ 6 months – 1 year ❑ More than 1 year

66. How do you rate the care that your child receives at this clinic?
❑ Excellent ❑ Fair ❑ Poor
Please comment on your answer:

67. Would you recommend this clinic to other parents/caregivers looking for a place to take a child for health care?
❑ Yes ❑ No ❑ Unsure
Please comment on your answer:

Appendix B: Table of Selected Data on Clinics Visited

	CHILD HEALTH CLINICS		COMMUNICARE CLINICS		TOTAL	
	N=19	% yes	N=5	% yes	N=24	% yes
GENERAL INFO						
Hours of Operation						
Weekdays 8:30 - 4:30	11	57.9%	0	0%	11	45.8%
Weekdays + eve	3	15.8%	3	60%	6	25.0%
Weekdays + sat	3	15.8%	1	20%	4	16.7%
Weekdays + eve & sat	2	10.5%	1	20%	3	12.5%
Number of staff: average	9.6		10.6		10.0	
Age Range served						
0-12	6	31.6%	0	0%	6	25.0%
0-18	10	52.6%	5	100%	15	62.5%
0-21	3	15.8%	0	0%	3	12.5%
PRIMARY CARE						
Clinic staff make home visits	12	63.2%	3	60%	15	62.5%
Reasons home visits are made						
Routine assessment	0	0.0%	0	0%	0	0.0%
Urgent care	3	15.8%	2	40%	5	20.8%
Family unable to come to clinic	0	0.0%	0	0%	0	0.0%
To follow up on a missed appointment	3	15.8%	1	20%	4	16.7%
Other	8	42.1%	3	60%	11	45.8%
Clinic follows up on missed appt by						
Home visit	2	10.5%	1	20%	3	12.5%
Telephone call	19	100.0%	5	100%	24	100.0%
Mailed appointment card or letter	16	84.2%	5	100%	21	87.5%
No follow up	0	0.0%	0	0%	0	0.0%
Other	3	15.8%	0	0%	3	12.5%
Children have same practitioner at all visits?	17	89.5%	5	100%	22	91.7%
Waiting time for hearing evaluation						
Less than six weeks	17	89.5%	4	80%	21	87.5%
6 weeks - 3 months	2	10.5%	1	20%	3	12.5%
More than 3 months	0	0.0%	0	0%	0	0.0%
Waiting time for vision screening						
Less than six weeks	15	78.9%	4	80%	19	79.2%
6 weeks - 3 months	4	21.1%	1	20%	5	20.8%
More than 3 months	0	0.0%	0	0%	0	0.0%
Lab work is done on site	14	73.7%	4	80%	18	75.0%
Medications are dispensed on site	19	100.0%	5	100%	24	100.0%
Clinic runs out of medications and/or supplies						
Often	4	21.1%	1	20%	5	20.8%
Sometimes	9	47.4%	1	20%	10	41.7%
Never	6	31.6%	3	60%	9	37.5%
Clinic runs out of...						
Vaccines	2	10.5%	2	40%	4	16.7%
Medications	11	57.9%	2	40%	13	54.2%
Laboratory supplies	1	5.3%	2	40%	3	12.5%
Medical supplies	4	21.1%	1	20%	5	20.8%
Office supplies	5	26.3%	1	20%	6	25.0%
Educational materials	2	10.5%	1	20%	3	12.5%
Other (includes cleaning supplies)	3	15.8%	1	20%	4	16.7%

	CHILD HEALTH CLINICS		COMMUNICARE CLINICS		TOTAL	
	N=19	% yes	N=5	% yes	N=24	% yes
PUBLIC HEALTH						
All staff members are trained in asthma management	14	73.7%	3	60%	17	70.8%
Clinic has a reading program	5	26.3%	2	40%	7	29.2%
Social service referrals are made to						
HHC network office	8	42.1%	5	100%	13	54.2%
New York City Human Resources Administration	6	31.6%	0	0%	6	25.0%
Are not made	0	0%	0	0%	0	0.0%
Other	5	26.3%	0	0%	5	20.8%
Clinic collaborated with DOH in past six months	8	42.1%	3	60%	11	45.8%
Staff training is provided	16	84.2%	5	100%	21	87.5%
PAYMENT FOR SERVICES						
Uninsured patients required to pay for services	0	0.0%	1	20%	1	4.2%
Barriers to providing care exist for						
Uninsured children	0	0.0%	0	0%	0	0.0%
Legal immigrants	0	0.0%	0	0%	0	0.0%
Undocumented immigrants	0	0.0%	0	0%	0	0.0%
Children who live outside neighborhood	0	0.0%	1	20%	1	4.2%
Children with other assigned primary care provider	6	31.6%	1	20%	7	29.2%
Clinic assists families with insurance applications	16	84.2%	5	100%	21	87.5%
Types of assistance	(N=18)				(N=23)	
Distribute Child Health Plus brochure	15	83.3%	4	80%	19	82.6%
Referral for Child Health Plus enrollment	9	50.0%	2	40%	11	47.8%
Referral for Medicaid enrollment	8	44.4%	2	40%	10	43.5%
Assist families in filling out forms	13	72.2%	5	100%	18	78.3%
Other	2	11.1%	1	20%	3	13.0%
PHYSICAL PLANT						
Entity that owns building housing clinic						
NYCHA	6	31.6%	2	40%	8	33.3%
HHC	0	0.0%	0	0%	0	0.0%
DOH	12	63.2%	2	40%	14	58.3%
Private owner	1	5.3%	1	20%	2	8.3%
Physical plant problems in past three months						
Often	2	10.5%	1	20%	3	12.5%
Sometimes	12	63.2%	3	60%	15	62.5%
Never	5	26.3%	1	20%	6	25.0%
Types of physical plant problems						
Electrical	1	5.3%	0	0%	1	4.2%
Telephone	4	21.1%	1	20%	5	20.8%
Structural	3	15.8%	0	0%	3	12.5%
Equipment	1	5.3%	1	20%	2	8.3%
Heat	5	26.3%	2	40%	7	29.2%
Other	2	10.5%	0	0%	2	8.3%
Length of time for problem to be fixed						
Less than 3 days	8	42.1%	2	40%	10	41.7%
Less than 1 week	3	15.8%	1	20%	4	16.7%
1 month	1	5.3%	0	0%	1	4.2%
Not yet fixed	3	15.8%	2	40%	5	20.8%

	CHILD HEALTH CLINICS		COMMUNICARE CLINICS		TOTAL	
	N=19	% yes	N=5	% yes	N=24	% yes
VOLUNTEER OBSERVATIONS						
Clinic clearly identified on outside	(N=18) 11	61.1%	4	80%	(N=23) 15	65.2%
Buzzer or security guard	13	68.4%	4	80%	17	70.8%
Child-size equipment and furnishings	(N=17) 9	52.9%	2	40%	(N=22) 11	50.0%
Equipment and furniture in good condition	18	94.7%	5	100%	23	95.8%
Child-appropriate games/books in waiting room	(N=17) 6	35.3%	3	60%	(N=22) 9	40.9%
Sufficient seating in waiting room	17	89.5%	5	100%	22	91.7%
Clean and neat exam rooms	(N=18) 18	100.0%	5	100%	(N=23) 23	100.0%
Exam rooms have doors	(N=17) 17	100.0%	5	100%	(N=22) 22	100.0%
Telephone available to families	(N=15) 13	86.7%	3	60%	(N=20) 16	80.0%
Television on in waiting room	15	78.9%	2	40%	17	70.8%
Clean restroom for patients and families	(N=18) 18	100.0%	5	100%	(N=23) 23	100.0%

Appendix 1: Task Force Members

Edythe First, Chair
Felice Burns, Chair
Bonnie Bach
Priscilla Barnes
Helen Cooper
Louis Cooper, MD
Nicholas Cunningham, MD
Carol Feinberg
Leslie Gimbel
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Katherine Lobach, MD
Nancy Locker
Daniel Lufkin
Martha Olson, Esq.
Phyllis Rovine
Nancy Schacht
Jean Schrag
Elizabeth Sheehan
Paul Smetko, PhD
Nancy Solomon
Serita Winthrop
Donna Tiburzi, Student Intern

Appendix B: Listing of Clinics

BRONX

Generations Plus Network[57]

Daniel Webster Houses – 401 East 168th Street *
Forest Houses – 1005 Tinton Avenue
James Monroe Houses – 816 Soundview Avenue
John Mitchel Houses – 185 Willis Avenue *
Melrose Houses – 348 East 156th Street *

North Bronx Network

Glebe Avenue – 2527 Glebe Avenue *
Gunhill Pediatric Primary Care Center – 3450 White Plains Road
Tremont Avenue Communicare – 1932 Arthur Avenue *

BROOKLYN

South Brooklyn/Staten Island Network

Brevoort Houses – 258 Ralph Avenue
Brownsville – 259 Bristol Street *
Crown Heights – 1218 Prospect Place *
Eleanor Roosevelt Houses – 388 Pulaski Street *
Fifth Avenue – 665 Fifth Avenue *
Howard Houses – 1620 East New York Avenue
Sutter Avenue – 1091 Sutter Avenue

North Brooklyn Network

Bushwick Communicare – 335 Central Avenue *
Fort Greene – 295 Flatbush Avenue Extension *
Jonathan Williams Houses – 333 Roebling Street
Lafayette Houses – 434 Dekalb Avenue
Sumner Avenue Houses – 47 Marcus Garvey Boulevard
Williamsburg – 151 Maujer Street *
Wyckoff Gardens Houses – 266 Wyckoff Street *

Coney Island Hospital Network

Homecrest – 1601 Avenue S *
Luna Park Houses – 2817 West 12th Street
Sheepshead Bay Houses – 3525 Nostrand Avenue*

MANHATTAN

South Manhattan Network

Alfred Smith Houses Communicare – 60 Madison Street*
Baruch Houses – 280 Delancey Street

Generations Plus Network

East Harlem – 158 East 115th Street *
Riverside – 160 West 100th Street

Renaissance Network

Alexander Hamilton Houses – 2690 Eighth Avenue
Dyckman Houses Communicare – 175 Nagle Avenue*
Manhattanville – 21 Old Broadway *
St. Nicholas Houses – 281 West 127th Street
Washington Heights – 600 West 168th Street

STATEN ISLAND

South Brooklyn/Staten Island Network

Hylan Avenue Communicare – 2971 Hylan Boulevard*
Mariner's Harbor Houses – 142 Brabant Street
St. George – 51 Stuyvesant Place *
Stapleton – 111 Canal Street

QUEENS

Queens Network

Astoria – 12-26 31st Avenue
Corona – 101-04 Corona Avenue *
Junction Boulevard – 34-33 Junction Boulevard *
Jamaica-Parsons – 90-37 Parsons Boulevard *
Ridgewood Communicare – 769 Onderdonk Avenue
Waltham – 146-39 105th Avenue
Woodside Houses – 50-53 Newtown Road

** Indicates clinic was part of CCC study*

57 The Forest Houses, John Mitchel Houses, and Daniel Webster Houses were closed at the time of publication of this report, due to structural problems.

Appendix I:
Map of Child Health Clinics and Communicare Clinic Sites

Appendix A:
Map of Other Publicly-Supported Primary Care Services for Children

KEY
PROVIDERS OF PRIMARY CARE FOR CHILDREN

1 Bedford Medical FHC
2 Bedford Stuyvesant Family HC
3 Brookdale University Family Care Center
4 Brookdale University Family Care Center
5 Brookdale University Pediatric Resource Center
6 Brookdale University Urban Strategies
7 Brooklyn Hospital Center
8 Brooklyn Plaza MC
9 Brownsville FHC
10 Coney Island Hospital
11 Cumberland D & TC
12 East New York D & TC
13 Interfaith MC Lola Cuffee FHC
14 Interfaith MC Ralph Avenue
15 Interfaith MC St. John's
16 Interfaith Medical Center FHC
17 Jamaica Hospital MC Medisys
18 Kings County Hospital Center
19 Long Island College Hospital
20 Long Island College Hospital Family Care
21 Lutheran MC Park Slope
22 Lutheran MC Sunset Park
23 Lyndon Johnson Health Complex
24 Maimonides Medical Center
25 New York Community Hospital
26 New York Methodist Hospital
27 Sister Thea Bowman HC
28 St Mary's Hospital Charles Drew FHC
29 St Mary's Hospital Pediatric Clinic
30 St Mary's Hospital Sister Lucian Lucchi FH
31 St Mary's Hospital St Francis
32 St Mary's Hospital St Peter Claver
33 SUNY University Hospital FHC
34 Victory Memorial Hospital
35 Woodhull M&MHC VIP Clinic
36 Wyckoff Hospital Patrick F. Daly FHC
37 Bronx-Lebanon Hospital Center
38 Calvary Hospital
39 Dr. Martin Luther King Health Center
40 Hunts Point Pediatric Clinic
41 Jacobi Hospital
42 Juan Ponce DeLeon Pediatric Clinic
43 Lincoln Hospital Medical Center
44 Montefiore Family Health Center
45 Montefiore Medical Center
46 Montefiore Medical Center D&TC
47 Montefiore Pediatric Clinic
48 Morris Heights Pediatric Clinic
49 Morris Heights Pediatric Clinic
50 Morrisania D&TC
51 Neighborhood & Family HC
52 North Central Bronx Hospital
53 Our Lady of Mercy MC
54 Our Lady of Mercy Pediatrics
55 Ronald Fraser Health Center
56 Segundo Ruiz D & TC
57 Soundview Health Center
58 St Barnabas
59 Urban Health Plan
60 Westchester Square Hospital
61 Bellevue Hospital PRC
62 Betances Health Center
63 Beth Israel Medical Center
64 Boriken Health Center
65 Cabrini Medical Center
66 Center for Comprehensive Health Practices
67 Central Harlem Group
68 Coler/Goldwater Hospital
69 Community HealthCare Network
70 CPMC 180th Street
71 CPMC Audubon Clinic
72 Governeur D&TC
73 Gracie Square Hospital
74 Harlem Hospital Center
75 Metropolitan Hospital Center
76 Mt. Sinai Medical Center
77 New York Hospital Cornell MC
78 North General Hospital
79 NYU Downtown Hospital
80 Rockefeller University Hospital
81 Ryan-NENA Community HC
82 Settlement Health Plaza
83 Sidney Hillman Family Practice
84 St Lukes - Roosevelt Hospital Center
85 St Lukes - Roosevelt Hospital Center
86 St Vincent's Hospital and MC
87 St Vincent's Hospital Chelsea
88 St Vincent's Hospital Chinatown
89 Sydenham D&TC
90 William F. Ryan Community Health Center
91 Catholic Medical Center
92 Elmhurst Hospital
93 Jamaica Hospital MC
94 Jamaica Hospital MC Clocktower
95 Jamaica Hospital MC Goethals
96 Jamaica Hospital MC Goodwill
97 Jamaica Hospital MC Howard Beach
98 Jamaica Hospital MC Jamaica
99 Jamaica Hospital MC Richmond Hill
100 Jamaica Hospital MC Saratoga
101 Jamaica Hospital MC Springfield
102 Jamaica Hospital MC St. Albans
103 Joseph P. Addabbo FHC
104 LI Jewish MC/Schneider Children's Hospital
105 Mary Immaculate Hospital
106 New York Flushing Hospital MC
107 New York Hospital - Theresa Lang Children's Center
108 Peninsula Hospital Center
109 Queens Health Services Family Care Center
110 Queens Hospital Center
111 Queens Hospital Center
112 Queens Hospital Center PRC
113 St John's Episcopal Hospital
114 St John's Queens Hospital
115 Western Queens Community Hospital
116 Doctor's Hospital of Staten Island
117 Staten Island University Hospital
118 Staten Island University Hospital
119 Sisters of Charity

Appendix G[58]
Child Health Clinics Users - FY'93 Through FY'98

	FY'93 USERS	FY'94 USERS	FY'95 USERS	FY'96 USERS	FY'97 USERS	FY'98 USERS
NORTH BRONX	**10,640**	**8,812**	**8,574**	**9,081**	**9,065**	**8,710**
Glebe Avenue CHC	2,557	2,488	2,228	2,250	2,028	1,967
Gunhill Houses CHC	2,867	2,410	2,450	2,550	2,383	2,085
J. Monroe Houses CHC	1,663	1,188	941	1,056	1,273	1,524
Tremont CHC	3,553	2,726	2,955	3,225	3,381	3,134
GENERATIONS PLUS	**9,248**	**8,736**	**8,129**	**8,699**	**8,924**	**8,454**
Forest Houses CHC	1,516	1,385	1,206	1,235	1,132	1,118
J. Mitchel Houses CHC	1,607	1,542	1,572	1,484	1,623	1,373
Melrose Houses CHC	1,148	530	321	1,089	1,220	1,155
D. Webster Houses CHC	1,226	1,522	1,503	1,648	1,638	1,648
East Harlem CHC	2,825	2,698	2,605	2,321	2,363	2,187
Riverside CHC	926	1,059	922	922	948	973
NORTH MANHATTAN	**9,335**	**7,666**	**7,772**	**8,285**	**8,305**	**8,075**
A. Hamilton Houses CHC	1,462	1,151	888	809	657	736
Manhattanville Houses CHC	2,904	2,680	2,351	2,445	2,399	2,384
St. Nicholas Houses CHC	786	836	1,203	1,416	1,494	1,256
Washington Heights CHC	1,973	2,999	3,330	3,615	3,755	3,699
Dyckman Houses CHC	2,210	Temporarily Closed for Renovation - Converted to Communicare 9/98				
SOUTH MANHATTAN	**4,054**	**3,119**	**2,057**	**1,852**	**1,562**	**1,383**
Baruch Houses CHC	1,760	2,371	2,057	1,852	1,562	1,383
Gov. Smith Houses CHC	2,294	748	Temporarily Closed for Renovation - Converted to Communicare 6/98			
QUEENS	**19,497**	**15,681**	**16,339**	**17,405**	**16,258**	**15,385**
Junction Blvd. CHC	6,696	6,284	6,229	6,799	6,501	5,880
Astoria CHC	2,493	1,759	1,991	1,883	1,560	1,469
Woodside Houses CHC	749	683	563	705	635	992
Corona Avenue CHC	2,344	1,724	1,900	2,438	2,251	2,329
Jamaica-Parsons CHC	6,030	3,341	3,801	3,696	3,513	3,251
Waltham CHC	1,185	1,890	1,855	1,884	1,798	1,464

[58] New York City Health and Hospitals Corporation. September 1999.

Appendix 6 (continued)
Child Health Clinics Users - FY'93 Through FY'98

	FY'93 USERS	FY'94 USERS	FY'95 USERS	FY'96 USERS	FY'97 USERS	FY'98 USERS
BROOKLYN NORTH	**21,536**	**19,069**	**17,994**	**17,536**	**16,218**	**17,314**
Lafayette Houses CHC	1,986	1,893	1,794	1,671	1,598	1,429
E. Roosevelt Houses CHC	1,853	2,175	2,327	1,934	1,906	1,785
Sumner Ave. Houses CHC	2,456	2,371	2,096	2,115	1,677	1,338
J. Williams Houses CHC	2,299	2,291	2,223	2,456	2,382	2,427
Irving Avenue CHC	1,808	1,744	1,883	1,897	1,883	1,007
Williamsburg CHC			CLOSED FOR RENOVATIONS			1,973
Ft. Greene CHC	3,579	3,195	2,724	2,348	2,395	2,821
Wyckoff Gardens Houses CHC	1,474	1,249	1,050	1,188	812	809
Bushwick CHC	6,081	4,151	3,897	3,927	3,565	(CC) 3,725
BROOKLYN SOUTH/ STATEN ISLAND	**14,774**	**11,848**	**11,768**	**12,810**	**12,524**	**13,057**
Brevoort Houses CHC	1,066	1,043	982	1,024	869	741
Crown Heights CHC	3,691	3,320	3,094	2,968	2,684	2,829
Howard Houses CHC	2,847	2,710	2,263	1,894	1,495	1,525
Sutter Avenue CHC	1,481	1,477	1,421	1,525	1,500	1,403
Brownsville CHC	785	CLOSED FOR	RENOVATIONS	795	1,579	2,248
Fifth Avenue CHC	1,187	916	1,745	2,469	2,456	2,285
St. George CHC	1,230	940	823	731	1,158	1,236
Mariner's Harbor Houses CHC	523	590	537	578	783	790
Stapleton CHC	807	852	903	826	CLOSED FOR RENOVATIONS	
Hylan Blvd. CHC	1,157	COMMUNICARE	COMMUNICARE	COMMUNICARE	COMMUNICARE	870
CONEY ISLAND	**6,069**	**5,701**	**5,299**	**5,425**	**5,583**	**5,358**
Homecrest CHC	2,879	2,691	2,665	2,898	3,117	3,114
Sheepshead Bay Houses CHC	1,765	1,682	1,467	1,505	1,439	1,308
Luna Park Houses CHC	1,425	1,328	1,167	1,022	1,027	936
CLOSED						
Polo Grounds Houses CHC	1,069	979	CLOSED	CLOSED	CLOSED	CLOSED
Geo. Washington Houses CHC	663	320	CLOSED	CLOSED	CLOSED	CLOSED
John Adams Houses CHC	496	513	342	CLOSED	CLOSED	CLOSED
Sunset Park CHC	2,950	2,856	1,527	CLOSED	CLOSED	CLOSED
CITYWIDE	**100,331**	**85,300**	**79,801**	**81,543**	**78,439**	**77,736**

Appendix G (continued)
Child Health Clinics Visits - FY'97 and FY'98

	CLINICAL		PUBLIC HEALTH	
	FY'97	FY'98	FY'97	FY'98
NORTH BRONX	**22,282**	**22,130**	**7,074**	**5,466**
Glebe Avenue CHC	5,619	5,772	1,538	1,167
Gunhill Houses CHC	5,405	5,119	1,704	1,243
J. Monroe Houses CHC	2,760	3,057	910	878
Tremont CHC	8,498	8,182	2,922	2,178
GENERATIONS PLUS	**25,861**	**24,536**	**6,628**	**5,228**
Forest Houses CHC	3,132	3,213	922	856
J. Mitchel Houses CHC	4,566	3,851	954	751
Melrose Houses CHC	3,807	3,478	1,066	752
D. Webster Houses CHC	4,065	4,073	1,315	1,096
East Harlem CHC	7,618	7,219	1,693	1,021
Riverside CHC	2,673	2,702	678	752
NORTH MANHATTAN	**23,656**	**23,036**	**5,999**	**4,815**
A. Hamilton Houses CHC	1,712	2,507	460	487
Manhattanville Houses CHC	7,381	7,796	1,806	1,460
St. Nicholas Houses CHC	3,404	2,967	1,025	845
Washington Heights CHC	11,159	9,766	2,708	2,023
SOUTH MANHATTAN	**3,868**	**3,468**	**1,037**	**919**
Baruch Houses CHC	3,868	3,468	1,037	919
Gov. Smith Houses CHC	N/A	N/A	N/A	N/A
QUEENS	**33,802**	**31,895**	**13,758**	**10,640**
Junction Blvd. CHC	12,556	10,945	4,653	3,358
Astoria CHC	3,007	2,916	1,911	1,642
Woodside Houses CHC	992	2,380	931	855
Corona Avenue CHC	6,604	6,097	2,061	1,667
Jamaica CHC	6,983	6,296	2,901	2,045
Waltham CHC	3,660	3,261	1,301	1,073

Appendix G (continued)
Child Health Clinics Visits - FY'97 and FY'98

	CLINICAL		PUBLIC HEALTH	
	FY'97	FY'98	FY'97	FY'98
BROOKLYN NORTH	**37,624**	**44,615**	**11,070**	**8,626**
Lafayette Houses CHC	2,038	2,424	2,911	1,686
E. Roosevelt Houses CHC	6,854	5,881	1,167	857
Sumner Avenue Houses CHC	5,750	3,693	886	525
J. Williams Houses CHC	7,779	6,344	1,616	2,854
Williamsburg CHC	CLOSED	5,589	CLOSED	608
Ft. Greene CHC	4,827	6,145	1,383	1,575
Wyckoff Gardens Houses CHC	1,853	2,139	796	521
Bushwick CHC	8,523	12,400	2,311	N.A.
BROOKLYN SOUTH/ STATEN ISLAND	**31,600**	**32,892**	**8,411**	**7,828**
Brevoort Houses CHC	2,375	2,222	702	412
Crown Heights CHC	5,156	5,362	1,807	2,163
Howard Houses CHC	4,417	4,857	746	604
Sutter Avenue CHC	4,659	3,691	850	463
Brownsville CHC	4,141	5,950	962	1,238
Fifth Avenue CHC	6,056	5,614	1,817	1,521
St. George CHC	2,277	2,650	925	951
Mariner's Harbor Houses CHC	2,519	2,546	602	476
Stapleton CHC	CLOSED	CLOSED	CLOSED	CLOSED
CONEY ISLAND	**12,099**	**11,059**	**3,957**	**3,113**
Homecrest CHC	6,648	6,288	2,086	1,498
Sheepshead Bay Houses CHC	3,521	2,623	1,011	767
Luna Park Houses CHC	1,930	2,148	860	848
CITYWIDE	**198,620**	**195,713**	**58,596**	**47,461**

Notes

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